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ABSTRACT

The Medical Interpreter Training Project, created as a collaborative effort of Northern Essex Community College (Massachusetts), private businesses, and medical care providers in Massachusetts, developed a 28-credit, competency-based certificate program to prepare bilingual adults to work as medical interpreters in a range of health care settings. Participation in the program was targeted to two major linguistic groups in the area: Spanish- and Khmer-speaking adults. The first college-level program in the United States, the Medical Interpreter Certificate Program is organized around three essential areas of knowledge and skills that a medical interpreter must have: skills in spoken language interpretation, multicultural perspectives, and medical content. The pilot group of about 20 students were all placed in jobs. The project also developed professional standards of practice that now serve to guide on-the-job performance evaluation, supervision, and inservice training. (Appendixes to the report include project development information, a needs survey, medical interpreter program competencies, language assessments, standards of practice, and also contains 11 references.) (KC)

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THE MEDICAL INTERPRETER TRAINING PROJECT

Cover Sheet

Grantee Organization:

Education Development Center, Inc.
55 Chapel St.
Newton, MA 02158-1060

Grant Number:

P116 B20542

Project Dates:

Starting Date:	August 15, 1992
Ending Date:	August 14, 1995
Number of Months:	36

Project Director:

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FIPSE Program Officer:

Jay Donahue

Grant Award:

Year 1	$121,744
Year 2	$128,991
Year 3	$129,999
	$380,734

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The MEDICAL INTERPRETER TRAINING PROJECT

Project Summary

The Medical Interpreter Training Project developed a 28-credit, competency-based certificate program to prepare bilingual adults to work as medical interpreters in a range of health care settings. The first college-level program in the United States, the Medical Interpreter Certificate Program is organized around three essential areas of knowledge and skill that a competent, professional medical interpreter must have: (1) skills in spoken language interpretation within the triadic relationship of provider-patient-interpreter; (2) multicultural perspectives in health care; and (3) medical content. It is designed to equip bilingual adults with immediately marketable skills while also introducing them to other careers in the allied health fields. The project also developed professional standards of practice that now serve to guide on-the-job performance evaluation, supervision, and inservice training. Through an innovative, interdisciplinary team approach, the project generated significant insights into the teaching and learning processes that are effective with bilingual adult learners who are new to higher education.

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Project Reports and Products

- Medical Interpreter Program Manual
- Medical Interpreter Standards of Practice
- Year 2: Annual Report

EXECUTIVE SUMMARY

Project Title: The Medical Interpreter Training Project

Grantee Organization: Education Development Center, Inc.
55 Chapel Street
Newton, MA 02158-1060

Project Director: María-Paz Beltrán Avery
(617) 969-7100

A. PROJECT OVERVIEW

The Medical Interpreter Training Project was developed as a response to two major needs in the area of health care provision: providing quality health care to culturally and linguistically diverse populations and addressing the shortage of bilingual students who enter and succeed in allied health programs. The Medical Interpreter Training Project responded to these two needs by developing a competency-based, credit certificate program in medical interpreting. The program provides bilingual adults with immediately marketable skills while introducing them to course content, terminology, and experiences relevant to other allied health careers. By building on the bilingual and bicultural potential of this population, the program also increases the capacity of the community college to attract immigrant adults.

The project was constructed as a collaboration of Education Development Center, Inc., a research and development organization, and three major stakeholders: a community college (Northern Essex Community College), an acute care community hospital (Lawrence General Hospital), and a professional organization (Massachusetts Medical Interpreters Association). An innovative component of the project was the formation of an interdisciplinary team. This team developed a program framework that addressed the challenge of maintaining academic excellence while meeting a critical health service need and expanding the entry options for underrepresented linguistic groups. The diversity of perspectives represented on the team—composed of medical interpreters, faculty, administrators, health care providers, and community resources—resulted in an academic program that was well-grounded in the realities of this newly emerging field.

The primary groups served were as follows: (1) bilingual adults, many of whom had not considered higher education as a viable option; (2) college faculty and administrators, who gained substantive insights into the strengths and needs of this population of students; (3) health care providers and patients, who need the service to overcome significant language and cultural barriers; and (4) medical interpreters, for whom this project served as a catalyst for further legitimation.

B. PURPOSE

The inability of health care providers to communicate across language and cultural barriers with their patients is a serious problem facing the health care system. Dangers inherent in the practice of using untrained, adhoc interpreters are substantial, ranging from increased use of diagnostic testing, misdiagnosis, even

death. An essential step in meeting the need for and improving the quality of interpreter services is the availability of academic, competency-based educational programs tied to professional standards of practice, a code of ethics, and eventually a process of certification. The Medical Interpreter Certificate Program represents a ground-breaking response to this need for quality education in the preparation of medical interpreters.

C. BACKGROUND AND ORIGINS

The idea to develop a college-level certificate program in medical interpreting grew out of a community survey that identified this as a need. At about this time, Northern Essex Community College (NECC) was opening a satellite campus in this community and was eager to respond. Approached by EDC to create such a program, a collaborative partnership was formed.

D. PROJECT DESCRIPTION

The primary feature of the project is a 28-credit, certificate program in medical interpreting. The program consists of 10 courses covering three major content and skill areas: medical interpreting theory and practice, multicultural perspectives in health care, and medical content. Programmatic outcome competencies and professional standards of practice are clearly articulated. The project also implemented a substantively significant development process that built on collegial discussions across academic disciplines and practitioner experiences.

E. EVALUATION/PROJECT RESULTS

Evaluation centered on defining who participated in the program, describing how the program was carried out, and identifying its impact on the college and health care facilities.

Participation in the program was targeted to two major linguistic groups in the area: Spanish- and Khmer-speaking adults. The project decided to focus on two groups rather than a single group or many groups due to: manageability during the developmental stages, the scarcity of well-prepared medical interpreting instructors, and providing a broad sociocultural context for learning. The program, however, can be used with a multilanguage student body. Twenty-one students—14 Latino, 6 Cambodian, and 1 non-Latino Spanish-speaker—took at least one course in the sequence. A majority indicated that they had not previously considered going to college but were attracted to this program because of its content and importance to their community. Six completed the program; two others completed all but two courses. All students who completed or nearly completed the program have found jobs as staff or freelance interpreters. Their participation and success in the program has motivated family members to also pursue higher education opportunities.

The project achieved all programmatic objectives: development of curricula for new courses and revision of existing ones, articulation of comprehensive outcome competencies and professional standards of practice, and creation of a model for non-English language assessment. The process of generating and coaching a pool of potential interpreter/instructors was begun. NECC has demonstrated a commitment to continuing the program by investing in the

ongoing training of a staff member who is a certified court interpreter in instructional pedagogy. NECC is also currently offering courses in the program sequence in the Boston area where there is a larger pool of qualified candidates responsive to professional development opportunities. Presentations at national and international forums has disseminated the work to a broad range of audiences.

The impact of the project on the college has been substantive. The interdisciplinary development team approach raised difficult questions such as: setting entry requirements that do not immediately exclude underrepresented groups; reexamining the relationship of admission criteria to high outcome standards; and exploring instructional strategies and assessment methodologies that build on cultural strengths and respond to linguistic challenges. The result has been individual changes in teaching practices such as including more career content and applied skills in ESL classes and greater use of interactive instructional strategies and alternative assessments. Institutional responses include the development of "bridging programs" designed to introduce students to content-specific vocabulary prior to immersion in technical courses. The project has also increased awareness of the importance of including culture and language issues in the education of health care providers.

The impact on health care facilities and the profession of medical interpreting has been substantial. The project has generated momentum calling for critical assessment of interpreter skills and training providers on appropriate working relationships with interpreters and the dangers of using untrained personnel. Nationally, it has provided leadership in the professionalization of the field, while remaining sensitive to the unique needs of small, close-knit linguistic communities.

F. SUMMARY AND CONCLUSIONS

The Medical Interpreter Training Project created a first in the preparation of professional medical interpreters: an academic, 28-credit, competency-based certificate program. Other major outcomes include graduation and placement of a pilot cohort; introduction and affirmation of innovative instructional and assessment practices in the academic setting; establishment of professional standards of practice; and important insights into the complex interactions of second language proficiency, intelligence, and academic performance. The project highlighted the importance of building the theoretical and practical infrastructure as the foundation for the creation and implementation of programs in newly emerging fields. It brought to the surface and addressed critical issues of linguistic and cultural barriers to the delivery of quality health services.

G. APPENDICES

The following appendices are included: Information for FIPSE, Development Team, Program Proposal, Program Competencies, Language Assessments, Medical Interpreter Standards of Practice, and DACUM analysis.

FINAL REPORT

A. PROJECT OVERVIEW

The Medical Interpreter Training Project was developed as a response to two major needs in the area of health care provision. One need confronts the challenge of providing quality health care to culturally and linguistically diverse populations. The other addresses the shortage of bilingual students who enter and succeed in allied health programs at the community college.

The Medical Interpreter Training Project was designed to respond to these two needs by developing a competency-based, credit certificate program in medical interpreting at the community college level. The certificate program provides bilingual adults with immediately marketable skills in interpreting. Concurrently, the program introduces them to course content, terminology, and experiences relevant to other allied health careers and provides them with initial successes in higher education. By building on the bilingual and bicultural potential of this population, the program also increases the capacity of the community college to attract immigrant adults.

The project was constructed as a collaboration of Education Development Center, Inc., a research and development organization, and three major stakeholders: a community college (Northern Essex Community College), an acute care community hospital (Lawrence General Hospital), and a professional organization of medical interpreters (Massachusetts Medical Interpreters Association). Education Development Center, Inc. (EDC) offered expertise in the educational and sociocultural concerns of linguistic populations, interdisciplinary program and curriculum development, and the establishment of skill standards. EDC also effectively brokered a diversity of perspectives into a coherent whole. Northern Essex Community College (NECC) provided the academic knowledge base and the setting in which the certificate program would eventually be

institutionalized. NECC also brought to the project valuable experience garnered through their pioneering work in developing a nationally recognized associate's degree program in American Sign Language interpreting. Lawrence General Hospital (LGH) provided a local health care facility with an existing office of interpreter services; staff who were sympathetic to the need for qualified, competent interpreters; and experience in working with foreign-trained physicians for whom language was a barrier to achieving licensing in the United States. The Massachusetts Medical Interpreters Association (MMIA), although not initially one of the collaborating partners, became integral to the program's creation and implementation and the increased professionalization of the field. The MMIA brought to the project the invaluable experience and dedication of a core group of professional medical interpreters—many of whom were responsible for coordinating interpreter services at large teaching hospitals—and providing short-term training to volunteer, freelance, and paid interpreters. Their expertise and understanding of the demands as well as the controversies in the field were critical in grounding the development process in the realities of this newly emerging field.

An innovative and significant component of the project was the formation of an interdisciplinary team (Appendix B: Development Team.) This team developed a program framework that addressed the challenge of maintaining academic excellence while meeting a critical health service need and expanding the entry options for underrepresented linguistic groups in the community college population. Composed of professional medical interpreters, faculty members, college administrators, health care providers, and community resources, the development team grappled with difficult questions that touched on many issues facing higher education today. Among these issues were: (1) setting entry requirements that did not immediately exclude the potential students we were trying to reach, many of whom were already working as interpreters; (2)

reexamining the relationship of admission criteria to high outcome standards and what needed to happen in between; (3) defining program competencies in a field that was still undefined and minimally accepted in the workplace as a legitimate profession; and (4) exploring instructional strategies and assessment methodologies that build on the cultural strengths and respond to the linguistic challenges of this population of students.

The primary groups served were as follows:

- Bilingual adults: As a pilot program, student recruitment focused on the two largest linguistic communities in the geographic area closest to the college—Spanish and Khmer. These two communities also posed tremendous language and cultural barriers in the delivery of quality health care. Twenty-one students—6 Cambodian, 14 Latino, and 1 non-Latino Spanish speaker—completed at least 1 of the 10 courses that eventually formed the certificate program.
- College faculty and administrators: Eleven permanent faculty and administrators directly participated in the development of the certificate program. In addition, adjunct faculty and members of the medical interpreter community were involved as instructors and on-site practicum supervisors. The substantive, often difficult, discussions that ensued among this group raised important questions about the academic abilities, motivation, and potential of adult learners who did not have the expected credentials for entry into a community college. These discussions changed perceptions of what was possible and modified thinking about classroom instruction, resulting in improved learning experiences for all students.
- Professional medical interpreters: Both the project's development process and its concrete outcomes have impacted on the community of professional medical interpreters in Massachusetts and nationwide. It has done so by providing leadership in clearly articulating the parameters of the field and demonstrating the

components of an academic course of studies to prepare qualified, competent interpreters.

- Health care providers and patients: Health care providers, through their interactions with program students placed in their facilities, learned how to work effectively with interpreters. Ultimately, however, the availability of competent interpreters benefits the patient who is most in need.

Among the major outcomes of the project were:

- Creation of the first college credit medical interpreter certificate program
- Graduation and placement of a pilot cohort
- Introduction and affirmation of innovative instructional and assessment practices in the academic setting
- Establishment of professional standards of practice
- National recognition and leadership in the field

B. PURPOSE

The number of people in the United States for whom English is not their first language is increasing rapidly. In 1980, approximately 23 million people over the age of 5 spoke a language other than English at home; by 1990, this number had grown to about 30 million.[1] For the vast majority of these people, English-language proficiency is so limited that their ability to communicate effectively in times of stress and establish a therapeutic relationship with health care providers is seriously impaired.

The practice of using family, friends, strangers, employees, and other patients as adhoc interpreters is unfortunately widespread. This practice assumes that anyone with even rudimentary knowledge of two linguistic systems is capable of serving as an interpreter. However, data from a study of interpreter-assisted encounters using untrained, ad hoc interpreters indicates that anywhere from 23 to 52 percent of words and phrases were incorrectly interpreted.[2] Errors typically

committed include omissions, additions, substitutions, and editing, all of which can result in serious distortions of meaning.

Dangers inherent in this practice of using untrained, ad hoc interpreters are substantial. They range from ethical violations such as breaches of confidentiality and informed consent to misdiagnosis, noncompliance with treatment regimens, and even death. Health care costs can also increase as a result of inadequate interpretation. For example, physicians tend to order more diagnostic tests to make up for the lack of information or miss important diagnostic cues resulting in the patient returning repeatedly for the same complaint.[3]

An essential step in meeting the demand for and improving the quality of interpreter services is the availability of academically grounded, competency-based educational programs tied to professional standards of practice, a code of ethics, and eventually a process of certification. Historically, the preparation of medical interpreters in the United States has consisted primarily of short-term, inservice training provided by hospitals, other health care facilities, or community agencies concerned with immigrant and refugee populations.[4] Most of these trainings were composed of informational orientation sessions with little performance-based preparation in linguistic and interpreting skills. In the past five years, training programs at the University of Minnesota, University of Massachusetts Medical Center, and through the Cross-Cultural Health Care Program at Pacific Medical Center in Seattle, Washington, have dramatically improved the teaching and learning of medical interpreting skills. However, the only college credit programs available in interpreting were still only in American Sign Language and conference interpreting. The Medical Interpreter Certificate Program, developed through this project, represents a ground-breaking response to the need for quality education in the preparation of professional medical interpreters.

The biggest challenges faced by the project revolved around the tension between two equally valid concerns: creating an academically sound, college credit program while responding to the unique characteristics and qualifications of the targeted student population. Data on the educational levels of the target communities indicate that many potential students do not have the prior academic preparation that traditionally predicts success in postsecondary education in the United States. In short, most lack strong academic English-language skills. On the other hand, their commitment to the needs of their communities serves as a critical motivating factor for personal and collective success. In fact, the program did attract students with the above characteristics.

The above concerns were addressed in several ways during the pilot phase. One approach set appropriate, program-specific admission criteria. Knowing that the primary interpreting skill needed was oral comprehension and intelligibility in English and the other language, proficiency requirements in these areas were set higher than for those in reading and writing, specifically in English. However, this solution heightened another aspect of the problem: while the interpreting courses focused primarily on oral language skills, all the other courses, some of which were existing college offerings, still expected students to be able to read and write in English.

Several approaches were used to respond to this aspect of the problem. One approach provided supplementary support to the students as an integral part of the program. This was done by using team-teaching in the multicultural perspectives courses, two new offerings designed specifically for the program. The team consisted of a content instructor and an ESL instructor. The ESL instructor worked closely with students, assisting them in preparing their written assignments and providing helpful tips in how to read for comprehension. Workshops outside regular class times were also provided, focusing on topics such as study skills, how

to use a course syllabus to organize study time, comparison of expectations of students and instructors in the United States and in the students' countries of origin, and how to respond to misconceptions U.S. instructors may have about students who speak accented or grammatically flawed English.

While these proved to be highly effective strategies, they are not easily sustained by community colleges facing severe financial constraints. Team teaching is a costly pedagogical strategy. Furthermore, while most colleges have centralized academic support services, specialized assistance to cohesive cohorts of students is generally not provided. Yet, it is this kind of peer support model, rather than the individual initiative model, that most effectively motivates students new to higher education to avail themselves of the resources they need to succeed. Rather than waiting for individual students to come to them, academic support service programs might consider creating career- or discipline-related support groups to provide ongoing assistance in vocabulary, reading, and writing skills pertinent to that particular field of study.

Another approach, used to some degree by all the instructors in the program, incorporated a variety of interactive instructional and assessment strategies, encompassing a range of learning styles in the classroom. Among the strategies used were cooperative learning, integrated skills learning, interactive laser disc programs, self-analysis of videotaped work, and oral rather than written tests. These strategies, combined with a hands-on, performance-based approach to teaching and learning, proved to be very effective and instructors have begun to integrate them into their other classes.

C. BACKGROUND AND ORIGINS

The idea to develop a college-level certificate program in medical interpreting grew out of a study sponsored by the Massachusetts Board of Regents of Higher Education in 1988 on the needs of linguistic minority applicants to community colleges in

northeastern Massachusetts.[5] Training in interpreting was identified as a significant need by bilingual adults in the Lawrence area. At about the time this project proposal was written, NECC had just opened a Lawrence campus to better serve the large Latino community in that area. Noted for its range of offerings at the certificate and associate degree levels in allied health careers, NECC also has a nationally recognized associate's degree program in American Sign Language Interpreting. The collaboration among the need expressed by a linguistic community that has been underrepresented in higher education and health careers, the response from an institution of higher learning (NECC) eager to outreach into the community, and the interest of an educational research and development organization (EDC) was a critical one.

However, a creative tension was generated by the collaboration. The interdisciplinary, action/reflection development approach created by EDC was clearly not the norm within the community college. Usually, new programs are created by individual faculty, often with little assistance from colleagues. Implementation occurs only after approval from the academic committee is received. In the case of the Medical Interpreter Certificate Program, development and implementation occurred simultaneously and the program proposal was not finalized and approved until the pilot cohort of students was well into their courses. Nonetheless, this long-term, team approach proved to be substantively strong although often frustrating. Exit interviews with team members highlighted positive aspects of the process, such as the following: opportunity for collegial discussions among faculty, administrators, and outside resources on substantive issues; a deeper understanding of a range of teaching and learning styles; a heightened understanding of the motivations and potentials in this population of students; broadened appreciation of the importance of a multicultural focus and the

need to affirm differences in people; and the value of good interpretation to quality patient care.

Critical to the project's success was the commitment of key stakeholders at the community college. Faculty who were well respected in their disciplines were essential to the academic approval process. Support from administrators, in particular the academic dean, allowed for flexibility with organizational policies during the pilot phase. Although the project began without a clear determination of the department in which the program would eventually reside, once this became clear, the involvement and commitment of the pertinent assistant dean was invaluable. This kind of institutional buy-in was especially important in a project in which the day-to-day leadership was being provided from the outside. The establishment of an administrative partnership between the external and internal agents of change is one that needs to be created early in the collaboration if development and implementation are to proceed smoothly.

D. PROJECT DESCRIPTION

The primary feature of the project is a 28-credit, certificate program in medical interpreting that is now an official offering of Northern Essex Community College. The program consists of 10 courses, covering 3 major content and skill areas: medical interpreting theory and practice, multicultural perspectives in health care, and medical content. (Appendix C: Program Proposal.) All courses integrate knowledge acquisition with skill practice. Detailed curriculum plans for each of the courses are available in the *Medical Interpreter Program Manual*.

Using focused task groups, each composed of practitioners (interpreters and health care providers) and faculty, the knowledge base and skill areas required of effective medical interpreters were identified and programmatic outcome competencies were clearly articulated to guide the process of curriculum development and revision. (Appendix D: Program Competencies.) The

participation of a diversity of stakeholders in defining these competencies was especially critical given the undefined state of the medical interpreting field. Working closely with professional practitioners, the team developed a coherent theoretical and technical framework that recognized the controversies and provided a rationale for the decisions that were made.

E. EVALUATION/PROJECT RESULTS

Evaluation of the project centered on three major questions: (1) Who participated in the program? (2) Was the program carried out as intended? and (3) What impact did the program have on the college and health care facilities?

Who Participated in the Program?

The development team consciously chose to recruit students from the two linguistic groups that represented the greatest need and were the largest in the geographic area—Spanish and Khmer. Although the inclusion of students from other linguistic groups was considered, it was argued that limiting the pilot cohort to two linguistic groups would provide more manageability and focused learning during the initial developmental stages. At the same time, two linguistic groups would still provide a broader sociocultural context for the practice of interpreting than would be available if only one linguistic group was targeted.

This decision to restrict the number of linguistic groups was also made as a direct response to the scarcity of well-prepared instructors, to teach the interpreting courses. Although it would have been possible to use ASL interpreting instructors, it was important to build capability within the medical interpreter community and to address specific spoken language and cultural aspects unique to the health care setting. This issue will be discussed further in the following section.

Over 50 inquiries about the program were made over the three-year life of the project. Twenty-four individuals went through the admission process. Students

were admitted in two cohorts. A cohort of 10 participated in the first course—an introductory course in medical interpreting—offered during the first summer term of the project. In the fall, a second cohort of 13 students was admitted. Both cohorts then formed the pilot group. Because of the difficulty of finding qualified instructors for the interpreting courses, it was decided that another cohort would not be started; rather efforts would be focused on continuing the development of the courses and piloting the sequence during the life of the project.

Of the 23 students who were accepted into the program, 21 completed at least one course in the sequence. Data on the 21 show the following characteristics: 14 (67%) students were Latino; 6 (28%) were Cambodian; and 1 (5%) was a non-Latino Spanish speaker. Twelve (57%) were female and nine (43%) were male, ranging in age from their early 20s to early 40s. Twenty (95%) spoke a language other than English as their first language, although two were born and educated in the United States. Nine (43%) completed high school in the United States, ten (48%) in their country of origin, and two (9%) had a GED. Fourteen (67%) had some college experience but only one (5%) had completed an associate's degree. Six (28%) indicated that they had not previously considered going to college but were attracted by this program because of its content (medical interpreting) and its importance to their community.

Their work histories covered a range of professions such as firefighter, factory worker, nursing aide, community case worker, receptionist, secretary, surgical technician, phlebotomist, and interpreter. All had previous experience, formally or informally, as interpreters. Five (24%) were currently employed as interpreters and an additional five (24%) worked in medical or other settings where they were often called upon to serve as interpreters.

The majority of the students tested at levels of academic English proficiency that placed them in the "remedial" category. However, they compensated for their lack of academic English skills with determination and motivation.

Of the 21 students who completed at least one course in the program, 6 completed all the courses and received a certificate. While the rate of completion (28%) was not very high, one of the reasons cited for dropping out corresponds to a secondary outcome the project hoped to achieve, namely motivating bilingual adults to enter allied health careers. In fact, two students reported dropping out of the program because they had decided to pursue nursing instead and needed to save money for this. One student dropped out to finish a program in medical terminology and transcribing. The most significant reasons for not continuing, however, were job related. Two students went back to jobs from which they had been laid off. Others were unable to continue because of schedule conflicts with their regular jobs. One person accepted a job as an interpreter on the basis of having completed the first interpreting course and moved out of the area. Two others, who already had full-time jobs as interpreters, took only those courses they felt they needed to upgrade their skills. The students who were already working in health care settings received tuition reimbursement. However, it is important to further educate health care facilities as to the need for qualified interpreters and obtain their financial commitment in providing quality, skill-based education in medical interpreting.

Of the six students who received the certificate, one was Cambodian, four were Latino, and one was a non-Latino Spanish speaker. Two other students, a Cambodian and a Latina, completed all but two courses and are waiting for the courses they missed to be repeated in order to complete the requirements.

All eight students who completed most or all of the requirements are currently working in some capacity as staff interpreters and/or freelancers. Two of

the students left previous jobs upon completion to accept new jobs as interpreters. Four continued in their previous jobs, two of whom already functioned as interpreters as part of their job. The other two supplement their regular income by doing freelance interpreting. One student, who was already working as a freelance interpreter doubled his income upon completion of the program. For those doing freelance work, fee for services range from $9 to $25 an hour, usually with a minimum guarantee of two to three hours pay per call.

Other outcomes reported by students in their exit interviews bear mentioning. Several students indicated that their success in this program has motivated their own children to think about and enter higher education. Several also mentioned that they intended to continue with their own education. Generally, all the students showed marked growth in confidence and assertiveness, not only in the workplace but also in other social interactions. Feedback from health care providers indicate that given a choice, they request to work with the graduates of the program rather than ad hoc, untrained interpreters, because of their professionalism and effectiveness. Coordinators of interpreter services who hire program graduates also speak highly of their skills and professional behavior.

Was the Project Carried Out as Intended?

All programmatic objectives were achieved. The Medical Interpreter Certificate Program was approved by the college's academic committee as a 28-credit program. A curriculum for each course as developed, along with comprehensive outcome competencies, professional standards of practice, and a model for non-English language assessment. (Appendix E: Language Assessments.) An admission process is also in place. (See Appendix C for a description of the admission process.)

The development and implementation process, however, underwent constant revision and modification, driven by an ongoing action/reflection, formative evaluation process. The original proposal proposed starting three cohorts

of students while the program was still in the process of development. This approach did not prove feasible or wise primarily because the instructional infrastructure needed to sustain such a schedule was not available. One of the major tasks the project faced was the identification and coaching of instructors to teach the medical interpreting courses and practicum supervisors for on-campus and field-site mentoring. This is a significant need that continues as the program moves toward expansion into other geographic areas within Massachusetts.

Although the project targeted only two linguistic groups, the issue of language compatibility between the interpreting instructor and the students also posed a problem. It is possible that if there had been spoken language interpreting instructors highly skilled in instructional and classroom management methodologies appropriate to heterogeneous student groupings, this issue might not have become a problem. Since this was not the case, however, student feedback strongly urged that having an instructor who spoke their language and understood their cultural experiences would be more effective and efficient. Using co-instructors, each representing one of the linguistic groups in the class, was a logical response. This was tried with two of the interpreting courses. A resource person from the linguistic group not represented by the primary instructor was provided full-time in one course and on an intermittent basis in another course. However, both these approaches bring problems that are difficult to address within the structure of community colleges. The primary problem is the increased cost attached to any form of team teaching or co-instruction. Another problem revolves around the practice of using adjunct faculty on which many community colleges rely. Team teaching, even when the co-instructor serves primarily as a intermittent resource person, requires joint planning for it to work effectively and efficiently. Adjunct faculty tend to have other full-time jobs and cannot do joint planning; they often arrive on campus only a few minutes before their class is scheduled. As the

program expands to include more linguistic groups, the question of linguistic and cultural compatibility with instructors will continue to present a challenge. Possible solutions might include the use of students as integral resources within the classroom as well as collaboration with cultural associations and agencies that focus on the needs of immigrant and refugee populations.

Students indicated their appreciation for having members from different cultures in classes other than interpreting, and particularly in the multicultural perspectives courses. In this respect, the decision to include more than one linguistic group in the pilot cohort provided added value. All the students cited both the personal and professional importance of learning that there are different ways of looking at the same situation.

The recruitment of qualified students from the geographic areas closest to the college also posed a problem. Although the initial English proficiency admitting criteria had been changed for the pilot cohort, there was considerable pressure within the community college to return to the criteria required of all students in credit programs. This meant that many of the potential candidates could not meet the college's English requirements prior to starting the program, considerably extending completion time. Another language-related problem that had not been fully anticipated was that many candidates who considered themselves bilingual, but had been born and educated in the United States, did not have adequate proficiency levels in the non-English language. This was especially true of many of the Latino candidates.

The small number of potential candidates is further exacerbated by scheduling problems. There is not a large enough pool to sustain either a full-time day program or a part-time evening program.

Recruitment in a wider geographic radius did not bring many tangible results. While potential students expressed enthusiastic interest in the program, travel time

and distance presented a major obstacle. Potential candidates in other geographic areas repeatedly requested having the program offered at their local community college. This, of course, would be desirable, if the problem of instructional capability can be addressed to cover other regions of the state where resources are even scarcer. One solution is to provide training-of-trainer opportunities. This was started on a small scale through the project, but to fully prepare competent interpreter instructors would require additional funding to design and run such a program. Another solution would be to rotate the location in which the program is offered. In September 1995, at the request of the MMIA, NECC began to offer several courses in the program sequence in the Boston area and will continue to do so in the coming semesters. Boston is an ideal location because of the number of teaching hospitals that already make use of paid interpreters, providing a large pool of qualified candidates who are responsive to professional development opportunities.

What Impact Has the Program Had on the College and Health Care Facilities?

Faculty and administrators cited the importance of engaging in substantive dialogue with their colleagues and with practitioners that challenged preconceived assumptions of what was possible with immigrant, adult learners who were not academically proficient in English. The result has been individual changes in instructional practice as well as institutional responses to student needs. Among the changes in instructional practice have been the inclusion of more career content and applied skills in ESL teaching and greater use of interactive instructional strategies and assessment methodologies. Institutional responses include the development of "bridging programs" designed to introduce students to content-specific vocabulary prior to their immersion in technical courses such as science, and increased interaction with organizations and ethnic resources in the community.

Another important impact the program has had on the college is the increased awareness among more faculty in the allied health careers of the importance of culture and language in the provision of health services. Although there seem to be some obstacles to using the newly created Multicultural Perspectives in Health Care courses as an elective in a number of the allied health programs, the discussion at least has started.

In conjunction with the MMIA, the project conducted an intensive problem-centered task analysis (Appendix F: Dacum Analysis.) of medical interpreting as it is currently practiced and developed professional standards of practice. (Appendix G: Medical Interpreting Standards of Practice.) These standards have been officially approved by the membership of the MMIA and will serve to guide on-the-job performance evaluation and supervision, and the provision of pre- and inservice training. These standards of practice have also been reviewed and enthusiastically received by a nationally representative group of interpreters, health care providers, and educators/trainers. The Joint Commission on Accreditation of Health Care Organizations is currently reviewing the standards as they revise their own accreditation standards.

Five hospitals participated directly in the program by providing practicum sites and field supervisors for the students. Coordinators of interpreter services and health care providers at these hospitals commented on the level of professionalism and confidence shown by the students. Two of these hospitals hired a graduate from the program, one full-time and another part-time. Two other hospitals continue to call on program graduates on a regular basis to provide freelance interpreting.

The parallel strands of creating a college-level certificate program in medical interpreting and the development of professional standards of practice have created a momentum at area hospitals calling for the critical assessment of the skills of paid and volunteer interpreters. At the same time, coordinators of interpreter services

and area health education committees (AHECs) have intensified their efforts to increase the awareness of health care providers to the dangers of using untrained interpreters and to prepare them to work effectively with professional interpreters.

Fourteen interpreter/trainers, representing all regions of Massachusetts, participated in a three-day training-of-trainers workshop sponsored by the project. Although the three-day workshop did not fully prepare participants to teach college-level courses in interpreting, it has impacted the quality of inservice training that is currently being provided at health care facilities.

The project has been represented at a number of national and international forums. The work has received acclaim as one of the few comprehensive, competency-based, academic approaches to the preparation of competent interpreters. It has been recognized through its leadership in defining program competencies and professional standards of practice as having contributed to the professionalization of the field, while remaining sensitive to the needs of small, close-knit linguistic communities. Presentations have been made at three major conferences: The League for Innovation in the Community College, Workforce 2000 Conference; the First International Conference on Community Interpreting in Legal, Health, and Social Service Settings held in Toronto, Canada; and the Henry J. Kaiser Family Foundation, Forum on Language Barriers in Health Care, held in Washington, D.C. The project was also a national collaborator in the Medical Interpreter Working Group that was sponsored by the Cross-Cultural Health Care Program at Pacific Medical Center in Seattle, Washington. Over 40 requests have been received for the *Medical Interpreter Program Manual*.

F. SUMMARY AND CONCLUSIONS

The Medical Interpreter Training Project created a first in the preparation of professional medical interpreters: an academic, competency-based certificate program. In the process, the project succeeded in generating substantive discussions

on the strengths of this student population and influenced instructional and assessment practices. It opened up discussions on extremely difficult topics such as second-language learning; intelligence and task performance; the capacity of higher education to respond to the felt needs of their communities; and the complex interactions of language, culture, and medical practice. The project took a hard look at the reality of what bilingualism and biculturalism mean as professional competencies in a field where misperceptions based on cultural misunderstanding could be the difference between life and death.

One important insight cited by college administrators and faculty recognized the unfair misconception of lower intelligence that is often placed on learners with limited or accented English. This realization prompted faculty to experiment with different ways of assessing student knowledge, such as by reading test questions aloud and accepting oral responses to test questions rather than relying on the more standard, written approach.

This project also highlighted the difference between developing an academic program in a field that is already established and developing a program in an emerging field. In the former case, the infrastructure is already present. There are academics and practitioners prepared in the discipline, there is a body of theoretical knowledge, and there are resources readily available. In the case of an emerging field, such as was the case with medical interpreting, such infrastructure is not available and needs to be created. Time spent in building the infrastructure prior to implementation is critical. A major achievement of the medical interpreter training project was the cultivation of this infrastructure. It articulated a coherent, integrated framework of theory and practice; it prepared instructors knowledgeable in both content and pedagogy; and it created innovative instructional resources.

The project also provided valuable insights on the teaching and learning of English for adult immigrant populations. Education in the United States is not

noted for producing highly competent bilingual adults. What passes for bilingualism is often minimal proficiency in two languages or highly skewed proficiency in one but not the other. The project, therefore, faced a unique dilemma—creating an academic program in which proficiency in two languages was critical for a pool of students whose language development in one or both languages was more of a potential than a reality. This dilemma, however, was successfully met by merging the teaching of academic content with language support. By providing ESL instruction in a context that had both personal and professional applications, progress was heightened and motivation maintained.

Understanding the unique needs of the target student population is therefore critical. In the case of medical interpreting, given the same characteristics of the student population as the pilot cohort, the following two recommendations should be considered: (1) developing a precertificate program at the ESL level focusing on dialogue and vocabulary relevant to health settings along with basic interpreting techniques; or (2) offering the program as noncredit. If the first recommendation is taken, such an ESL program could provide a career path to a credit certificate program or even an associate's degree program in medical interpreting.

The Medical Interpreter Training Project took a major first step in addressing critical issues of linguistic and cultural barriers to health care. The challenge, however, is much larger. The impact of language and culture in health care has implications for the education of a range of health care professionals. Our work on the project helped us identify significant areas of research and potential models of practice. We will continue our efforts by pursuing alternative sources of funding. We have also begun discussions with other FIPSE-funded projects interested in the same issues with the expectation that we might go back to FIPSE to fund our collaborative work.

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4. B.T. Downing, & K.H. Tillery. *Professional Training for Community Interpreters: A Report on Models of Interpreter Training and the Value of Training*/Minneapolis: Center for Urban and Regional Affairs, University of Minnesota, 1992.

5. J.A. Alomar. *City of Lawrence Educational Needs Analysis: A Demographic and Socioeconomic Context for Educational Reform.* Massachusetts Board of Regents of Higher Education, 1988.

G. APPENDICES

APPENDIX A
Information for FIPSE

Information for FIPSE

1. What forms of assistance from FIPSE were helpful to you? How can FIPSE more effectively work with projects?

The yearly project director meetings in Washington, D.C., were very helpful. The opportunities to share insights on similar concerns and issues have been useful and thought provoking. We welcomed the chance to network with other grantees and have leveraged these contacts to further the national dissemination of our project. The Translation Laboratory at the University of Iowa, for example, has written us into a grant they have submitted which will use distance technology to offer a modification of our Medical Interpreter Certificate Program and to improve access to interpreter services. We have also begun to discuss possibilities for collaborating with the Translation Laboratory and Hunter College in taking the next steps to further improve educational programs to prepare medical interpreters. However, we found the time allotted to meet individually with the program officer and the evaluation specialist was too limited.

The site visit from the program officer was especially helpful. It was important to hear about the trends and interests at FIPSE and in the federal government. However, this visit did not occur until the third year of the project. As the project director, I would have found it more useful if a visit had occurred at least once early in the life of the project and then again towards the end of the project. An early site visit would have provided an opportunity to involve the development team in a discussion with the program officer of the dilemmas we were facing.

2. What should the FIPSE staff consider in reviewing future proposals in your area of interest? What are emerging new directions? What are key considerations, given your type of project?

Our project opened up whole new arenas of practice, research, and skill that will be of paramount importance as the U.S. competes in the global economy. For example, linguistic and cross-cultural knowledge and skills have become vitally important in today's increasingly pluralistic society. The workplace is well aware that the competitive edge for the U.S. economy requires the emergence of a workforce that not only has technical skills but also has critical skills in interpersonal and cross-cultural communication. The integration of knowledge and

skills in these areas needs to be addressed at all levels of education, from K–12 through higher education. Unfortunately, in today's political climate, programs focusing on these issues are often misperceived as catering to an immigrant population uninterested in learning English and becoming part of U.S. society. It is important that FIPSE recognizes the motivational value of building on students' linguistic and cultural affinities as the basis for their successful entrance into U.S. society.

We would like to urge FIPSE to convene grantees and others to take a hard look at the intersections of language and culture, the provision of quality health care, and the education of health care providers. We encourage FIPSE to support programs that build on linguistic and cultural strengths as a way of motivating newly arrived immigrants, refugees, and bilingual adults not only to succeed in U.S. society but also to preserve the invaluable resources they bring. We at EDC would be very interested and willing to work with FIPSE in articulating new programs in these areas.

3. Other comments

FIPSE's reputation for being open to change and to learning from doing, even when mistakes are made, is something that we deeply appreciated. Being able to modify projected plans based on learnings from the field is a critical process that allowed us to take the significant steps that were necessary for success. These are aspects of FIPSE funding that we hope will continue.

APPENDIX B
Development Team

Medical Interpreter Training Program Development Team

Educational Development Center, 55 Chapel Street, Newton, MA 02158

- María -Paz Beltrán Avery , Director, Medical Interpreter Training Program
- Vivian Guilfoy, Director, Center for Education, Employment, and Community
- Gloryvee Hernández, Administrative Assistant, Medical Interpreter Training Program

Lawrence General Hospital, One General Street, P.O. Box 189, Lawrence, MA

- Nelson Matos, Director, Unlicensed International Graduate Programs
- Liliana Zagaría, Coordinator of Interpreter Services

Northern Essex Community College (Haverhill Campus) , Eliott Way, Haverhill, MA

- Robert McDonald, Dean of Academic Affairs
- Paul Bevilacqua, Chair, Division of Human Services and Health Professions
- Edward A. DeSchuytner, Chair, Department of Natural Science
- William Huston, Jr., Curriculum Coordinator, ASL
- Usha Sellers, Chair, Division of Social Sciences
- Pat Taglianetti, Coordinator, Medical Records Technology Program
- Carol Wallace, Director, Radiologic Technology Programs
- Jean A. Dyer, Coordinator, Health Education Support Center (1992–1993)

Northern Essex Community College (Lawrence Campus), 45 Franklin Street, Lawrence, MA

- Kathy Rodger, Director of Lawrence Campus
- Allan Hislop, Coordinator, ESL Services

Massachusetts Medical Interpreters Association

- Jane Crandall , Director of Interpreter Services, Beth Israel Hosptial, Boston, MA

The following members do not attend meetings but are regularly informed and consulted:

- John R. Dimitry, President, NECC
- Gerard J. Foley, Executive Vice President, Chief Operating Officer, Lawrence General Hospital
- Jose L. Silva, MD, Director , Work Health Programs, Lawrence General Hospital

Medical Interpreter Training Program

Consultants

- Margarita Battle, Director of Interpreter Services, Massachusetts General Hospital
- Raquel Cashman, Former Director of Interpreter Services, Boston City Hospital
- Yvonne Cheng, Medical Clinic Assistant, Healthwork Family Planning Clinic
- Jane Crandall , Director of Interpreter Services, Beth Israel Hosptial
- Maria Durham, Director of Interpreter Services, University of Massachusetts, Medical Center
- Sambath Chey Fennel, Former Project Director, Lowell Community/University Partnership
- Saly Pin-Riebe, Senior Service Advocate, Refugee Assistance Program, Department of Mental Health

Instructors

- Margarita Battle, Medical Interpreting I and II
- Jane Crandall, Medical Interpreting I
- Eric Giordano, Multicultural Perspectives in Health Care I and II
- Joanne Giordano, Multicultural Perspectives in Health Care I and II
- Robert Siggens, Human Biology
- Pat Taglianetti, Medical Terminology I and II

APPENDIX C
Program Proposal

MEDICAL INTERPRETER CERTIFICATE

BACKGROUND

In August 1992, Education Development Center, Inc. (EDC) received a three- year grant from the U.S. Department of Education, Fund for the Improvement of Post-Secondary Education (FIPSE) to develop a competency-based certificate program to prepare medical interpreters. This grant was awarded to the collaboration between EDC, Northern Essex Community College, and Lawrence General Hospital. The project's intended outcomes were the institutionalization of the program at Northern Essex Community College, and the development of program material including curricula, teaching materials, competencies, etc.

As part of the project design, a multidisciplinary development team composed of members from the three organizations was formed to plan, develop, and implement such a program. Key members of the professional medical interpreting community, many of whom are leaders of the Massachusetts Medical Interpreters Association (MMIA), were also involved.

Now in its second year of funding, the project has accomplished the following milestones:

- a broad framework for the program, including goals, general areas of knowledge, and skills to be addressed in the curriculum
- competencies for students to master by the end of the program
- an assessment tool for the target (non-English) languages
- entry criteria and an admissions process
- three courses available in the proposed sequence—Medical Interpreting I (offered twice); Human Biology; and Multicultural Perspectives I
- detailed course outlines for 7 of the 10 courses in the proposed sequence
- 21 students who have taken at least one course
- 15 students who are expected to continue taking courses in spring 94

The response from the medical interpreting community and health care facilities and associations has been very positive. Members of the MMIA continue

to be involved in the conceptualization, development, and implementation of the project. Health care facilities and associations support the enrollment of their staff by providing tuition reimbursement. Much work is being done to articulate the competencies and performance outcomes of each course and the overall program. This works is seminal to the work that is beginning in Massachusetts and across the nation to define national standards in the field.

PART I

A. Program Design

Medical Interpreter Certificate

Title		Contact Hours	Credits
First Semester			
MI	Medical Interpreting I	90	4
BI	Human Biology	45	3
SO	Multicultural Perspectives in Health Care I	45	3
HS	Medical Terminology I	15	1
Second Semester			
MI	Medical Interpreting II	90	4
MI	Introduction to Practicum	75	2
SO	Multicultural Perspectives in Health Care II	45	3
HS	Medical Terminology II	15	1
Third Semester			
MI	Medical Interpreting III	90	4
MI	Practicum I	135	3
		645	28

The Medical Interpreter Certificate Program (MICP) is a 28-credit, competency-based career program to prepare bilingual individuals to work as medical interpreters in a range of health care settings. The courses in the proposed program cover three essential areas of knowledge and skill that a competent, professional medical interpreter must have:

1. Skills in spoken language interpretation: The 3 medical interpreting courses and the 2 practicums are designed to progressively increase building blocks of knowledge and skill in the essential tasks of a medical interpreter. These tasks are: (1) provide accurate and complete interpretation of the meaning that is being conveyed; (2) effectively manage the communication process to support and enhance the relationship between the provider and the patient; (3) recognize and surface cultural factors that may intervene in the communication process and assist both the provider and patient in exploring these factors; and (4) maintain high professional and ethical standards. The focus of these courses is on performance—what the interpreter should be able to do and at what proficiency level. They are also the locus in which the knowledge base developed in the other courses are integrated into the complex practice of interpreting.

2. Knowledge of cultural factors: The 2 multicultural perspective courses introduce students to general elements of culture and the application of these concepts to the practice of medicine in the United States. In addition, students learn about the beliefs, values, and practices that impact on concepts of health and well-being and on the presentation, course, treatment, and outcome of illness. This sequence of courses also builds performance skills, such as perspective taking and the ability to ask appropriate questions to elicit relevant cultural information.

3. Knowledge of human biology and basic medical terminology: These courses familiarize students with the context and terminology of medicine as practiced in the United States so that the interpreter understands the assumptions that medical providers bring to the situation.

All courses are designed to provide and/or include both a knowledge base and a skill base. In other words, although the emphasis differs depending on the course, all courses address 2 outcome questions: (1) what does a competent medical interpreter need to know; and (2) what must a competent medical interpreter be able to do.

Entry criteria for students are as follows: (1) high school diploma or equivalency; (2) oral proficiency in English and a target (non-English) language; (2) fulfillment of the basic reading, writing, and math requirements in English; (3) ability to read and write at a basic level in the target language. Other qualifications are good interpersonal skills and exposure to a health care setting, including experiences in a volunteer capacity.

Applicants to the program will be required to undergo language assessment in both English and their target language and be interviewed by an admissions committee. The admissions committee will be composed of NECC faculty/staff including a member of the Admissions Office staff, and, if necessary, at least 1 person (preferably an experienced interpreter) who will be able to assess the applicant's level of bilinguality and biculturality.

B. **Description of the Program**

MICP will provide bilingual students with an opportunity to develop the skills, knowledge, and attitudes necessary to work as entry-level professional medical interpreters in a wide range of health care settings. The program also provides for career exploration within the health care field. Twenty-eight credit hours are required for the certificate.

The Interpreter Training Certificate program is a parallel program that prepares students to work with deaf persons. It differs from MICP in that it is a generalist program, while the Medical Interpreter Certificate focuses more specifically in the area of health care.

C. Accreditation and Evaluation

There is neither an accreditation body nor formal standards of practice for medical interpreting in the Commonwealth of Massachusetts or anywhere else in the United States. MICP is at the forefront of establishing these standards through the development of program competencies and performance standards for each medical interpreting course and for the program in general. The development of competencies and performance standards is being carried out in association with members of the Massachusetts Medical Interpreters Association.

Students have provided, and will continue to provide, regular feedback on the courses through a journal and through a structured interview at the end of each semester. The journal allows students to share their thoughts about the courses, the instructors, and the program in general. The project director reads these journals on a periodic basis. Careful to maintain the anonymity of the students, the project director shares the feedback with instructors to make adjustments and improvements in the courses.

Preliminary feedback from currently enrolled students has indicated a perceived improvement in job performance. Many of the currently enrolled students already work in the field as interpreters or in related jobs where they are often called upon to serve as interpreters. These students have reported that the knowledge and skills they learn in the courses have had a direct impact on their job performance. One student, for example, indicated that since she began taking courses she has felt more confident functioning as an interpreter and that as a result she has been called upon more often to interpret at the clinic where she works as a receptionist. Other students have reported that their newly acquired understanding of communication and cultural issues and their increased ability to communicate effectively has also had an impact in their personal lives.

Members of the development team and professional interpreters are involved in all phases of the development process and in reviewing material as it is developed. In addition, a national dissemination panel comprised of representatives from community colleges across the country will review the program and program material. The members of this panel are looking to this program as a model they may want to implement in their own settings.

D. **Purpose of the Program**

The program has several objectives:

1. To prepare competent, professional medical interpreters who will function in that capacity under the following conditions:
   a. interpret for provider and patient in a triadic relationship (provider-patient-interpreter); this program does not prepare interpreters to work alone with the patient
   b. use of the consecutive interpreting mode
   c. interpret not translate (oral interpretation, not written translation)

2. To interest bilingual adults in the allied health fields and to motivate them to pursue and succeed in such paraprofessional and professional careers

3. To contribute to the professionalization of a service that is needed to provide equitable, quality health care to speakers of languages other than English

4. To increase the capacity of the community college to attract and retain bilingual students

E. **Need for the Program**

The growing need for competent medical interpreters is underscored by the growing percentage of people in the United States who speak a language other than English at home. In 1980, about 23 million people over the age of 5 spoke a language other than English at home; by 1990, this number had grown to about 30 million—an increase of 40 percent. In Lawrence, a city of 60,000 people, half of the population speaks Spanish, and at least 25 percent of them are monolingual in Spanish.

The need for competent interpreters is driven not only by human compassion but also by legislative and regulatory pressures. For example, at the national level, Title VI of the Civil Rights Act and the Hill-Burton Act require

equitable provision of treatment for all patients who receive services funded totally or partially by federal funds. Also on the national level, the Patient Self-Determination Act requires that hospitals inform all patients of their right to make health care decisions and ask if they have advanced directives. Recognizing the diversity of today's population, the Joint Commission on Accreditation of Healthcare Organizations states in its manual, "The care of the patient includes consideration of the . . . cultural variables that influence the perception of illness." In addition, President Clinton's comprehensive health care plan has the potential for significantly increasing the number of consumers, especially those who are presently unserved and/or underserved.

Clearly, the need is imperative to provide a mechanism through which providers and patients who do not speak the same language can communicate. However, there is still a misconception that any level of bilinguality automatically qualifies a person to interpret. This notion, along with the urgency often found in many medical situations to communicate in any way possible with the patient, has led to the practice of recruiting the closest available person—family member, children, friends, or staff at the facility, from professional staff to custodial staff. But even under the best of circumstances, the role of medical interpreter requires unusual abilities. The ability to speak 2 languages is primary, but not the only essential skill. Interpreting back and forth during a medical interview requires special linguistic and cross-cultural communication skills as well as familiarity with basic medical concepts and terminology. Additionally, interpreters must have the skills needed to manage the triadic relationship of clinician-interpreter-patient while supporting the primary dyadic relationship of clinician-patient. Medical interpreters can best develop these critical skills through special training and practice.

The need for medical interpreters has been taken seriously by many Massachusetts hospitals, community health centers, and other medical facilities. In order to determine both the current use as well as the projected need for interpreters, a survey (see attached) was conducted of healthcare facilities in the Merrimack Valley area, Lynn and Salem areas, and key facilities in the Greater Boston and Worcester areas. To date, 16 surveys have been returned.

The results demonstrated that, in general, there is a growing need for this service and a recognition of the importance of providing easy access to interpreters. Some of the facilities that recently hired interpreter services coordinators reported an increase in utilization of services and/or improvement in the quality of services.

Of the 16 facilities that responded, 7 already have specifically designated coordinators of interpreter services, with 5 others coordinating these services through other offices such as Social Services, or other positions such as Nurse Manager. One of the facilities that coordinates services through the Clinic Manager is now considering creating a separate office of interpreter services. Of the 7 that have coordinators, 6 are full-time employees and one is part-time.

The demand for interpreters in different languages varies according to the area in which the facility is located, although Spanish was ranked first or second by 14 of the respondents and third by one. In the Merrimack Valley area, Khmer is ranked first by 2 out of the 7 respondents, and second by 3. Another growing language of need in this area appears to be Vietnamese. Other languages mentioned for the Merrimack Valley area are Portuguese, Laotian, Korean, and Chinese (no indication of which Chinese linguistic group) and in one hospital, ASL.

Outside the Merrimack Valley area, the following languages were ranked between first and third, depending on the location of the facility: Khmer, Russian, Vietnamese, Portuguese, and Haitian (Creole). Other languages mentioned were Italian, Polish, Greek, Cape Verdean, and Lebanese.

In general, it appears that there is a significant need in all areas for Spanish-speaking interpreters, with a growing need in Khmer and Vietnamese. In addition, depending on the geographic location of the facility, other languages are targeted.

Facilities use various methods to respond to the need for interpreting. Those facilities that have coordinators or a staff member with responsibility to provide interpreters tend to use on-staff volunteers or internal paid interpreters (full-time or part-time). On-staff volunteers are employees of the hospital who have other job functions but are bilingual and are called upon to interpret as needed. In-house paid interpreters are people whose job function is explicitly that of interpreter. These interpreters assume responsibility for coordinating all services at least during the

daytime hours in which they generally work (8 am to 4 pm). Ten of the 16 survey respondents had at least 1 in-house paid interpreter either full-time or part-time. Four of these facilities had more than 1 full-or part-time paid interpreter. One community health center relied on the fact that over 80 percent of their staff is bilingual.

Eleven of the 16 respondents also supplement their in-house capacity by having access to on-call interpreters or by working out arrangements with organizations in their community such as a language bank or an international institute.

All but 2 of the respondents indicate that the interpreters they use are paid. It is a positive sign that many facilities compensate interpreters for their services and do not simply rely on volunteers. Coordinators of interpreter services are paid salaries ranging from $20,800 to $40,000. Part-time or on-call freelance interpreters are paid in the range of $7.50 to $25 per hour, although 1 facility indicated paying up to $40 an hour for Khmer and Vietnamese interpreters.

Respondents were also asked whether or not their bilingual employees who were called on to interpret were given extra compensation for this additional function. Only 1 facility indicated that they did so, offering a 2 percent increase in pay. One facility paid employees for interpreter services when they provided this service outside their normal shifts. Five others indicated that this could be a possibility if employees were specifically trained as interpreters, although 1 coordinator indicated that while this would be fair the facility might not support such a practice. Still it appears that there is some precedent to compensate employees for an added-value skill.

The data indicates that there is a growing demand for paid interpreters, either through employment or on-call arrangements directly with a medical facility, or through an independent central clearinghouse such as a language bank. There are also indications that facilities are seeing the value of having a full-time coordinator of interpreter services on-site. Many of the current coordinators are newly hired employees, and at least one facility mentioned plans to hire a coordinator in the near future. In most instances, state agencies have required that hospitals hire an Interpreter Coordinator and that interpreting services be made available.

Facilities vary in their screening methods and in their expectations of entry-level qualifications for interpreters. Three facilities indicated that they did not screen interpreters, and only a few completed reference checks. One facility relied on the language bank they used. The majority relied on interviews to screen potential interpreters. A few mentioned such things as basic knowledge of medical terminology, education and work experience, and language skills when asked what entry-level qualifications were required. Only 1 facility explicitly mentioned having a speaker of the target language assess the language skills of the interpreter applicant. Educational expectations ranged from a high school diploma or GED, with experience and training as a medical interpreter preferred, to a graduate language degree. Nine facilities responded to this question: Their responses were as follows:

- two required a high school diploma
- two required an associate's degree, although one of these hired family planning counselors who then also did interpreting
- two required a bachelor's degree, with one other stating this as a preference but not a requirement
- one facility required a graduate language degree

None of the respondents named specific interpreting skills as a job qualification.

On-the-job training for external or internal paid or volunteer interpreters also varied by facility. Eight of the 16 did not offer any training. Of those that did, training time ranged from 2 hours to 30 hours, with some facilities supplementing this with regular staff meetings. The content of the training focused mainly on medical terminology and ethical and professional attitudes. Only 1 facility mentioned cross-cultural communications training.

It was apparent from the survey that this Medical Interpreter Certificate Program would fill a need that currently exists in the preparation and development of skilled medical interpreters.

Students have been recruited mostly from the Lawrence and Lowell areas through personal contacts in key agencies that serve the Latino community in Lawrence and the Cambodian community in Lowell. Word of mouth has been the most effective form of recruitment. Other recruitment activities included: fliers

posted in community agencies, presentations to local groups, informational brochures and personal calls to key persons in touch with potential students, and notices and articles in the *Boston Globe* (West and Northwest edition) and the *Eagle Tribune*, a Lawrence daily newspaper.

Recruitment for the first cohort of students resulted in 12 inquiries and the enrollment of 10 students, who started with 1 course in the summer of 1993. These 10 students range in age from early 20's to early 40's; 7 were Latino and 3 were Cambodian; five were women and five were men. Six of the original 10 have continued in the courses; 1 person decided not to continue because she of application to a nursing program; 1 person was called back to the job from which he had been laid off; 1 person had to find employment but has, in fact, now been employed on an on-call basis as an interpreter; and 1 person who already had a job as an interpreter did not realize the initial course was part of a sequence and decided not to continue.

Recruitment for the second cohort of students resulted in inquiries from 23 people including one person of Haitian descent. Thirteen students were accepted to take fall courses. Two students dropped out, 1 because he was called back to a job. Of the 11 students, 3 are Cambodian, 7 are Latino, and 1 is non-Latino but speaks Spanish.

F. **Faculty Requirements**

The courses will be offered through the Division of Continuing Education. Qualified faculty will be appointed in accordance with college policies and procedures.

Given the nature of the program, new faculty have to be hired to teach the interpreting courses. The experience of the past two years indicates that the interpreting courses are most effective when there is an instructor or co-instructors who speak the target languages of the students.

All other courses can be taught by existing faculty; the courses are most effective, however, when they are taught by faculty who are willing to use

innovative, interactive teaching techniques that reinforce not only the acquisition of knowledge but the application of such knowledge in performance outcomes.

G. **Similar Proposals/Options**

There are no other medical interpreter certificate programs in the United States at the college level.

References

Numbers and Needs: Ethnic and Linguistic Minorities in the United States, 2(January 1992)1.

Yohel Camayd-Freixas and YCF Associates. (1985). *Hispanics in Lawrence: A Demographic Analysis.* ERIC Document Reproduction Service No. #ED 326 085.

Joint Commission on Accreditation of Health Care Organizations (JCAHO). (1992). *Accreditation Manual for Hospitals.* Chicago: JCAHO.

Medical Interpreting Survey

The purpose of this survey is to gather data that will be used to determine the need for a program to prepare medical interpreters to work in acute care hospitals and other health care settings. The data which you provide will be used by the Medical Interpreting Project, a collaboration among Education Development Center, Northern Essex Community College and Lawrence General Hospital, to substantiate that need. It would be helpful if you would provide any additional supportive documentation which you might have, such as job descriptions, job postings, staffing patterns, salary schedules, salary projections, etc.

Date_____

Name and Title of person completing survey_____

Name of Institution /Agency _____

Type of facility (eg. acute, chronic, community health center, etc.)_____

1. What are the principal linguistic groups needing interpreting services at your facility? Rank order, with 1 being the highest need.

_____

_____

2. In what languages is your facility equipped to provide in-house interpreting resources?

_____

_____

3. In what areas of the facility are interpreters needed the most?

_____Emergency room
_____Outpatient
_____Gynecology/obstetrics
_____Pediatrics
_____Cardiology
_____Radiology
_____Neurology
_____Oncology
_____Other; specify _____
_____
_____
_____Inpatient
_____Other

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4. Does your facility have a coordinator and/or office of interpreter services?

_____No (Go to question 5)

_____Yes If yes, how is this office staffed? Indicate number of staff and whether paid or volunteer.

_____full-time person _____paid _____volunteer
_____part-time person _____paid _____volunteer
_____other, please explain

If yes, are all interpreter services at your facility coordinated through this office?

_____Yes _____No

5. What are the different methods your facility uses to meet the linguistic needs of patients who cannot communicate adequately in English? (Rank order all that apply with 1 being the method used most frequently)

_____rely on the patient bringing someone with them to interpret
_____ provider calls on a family member or friend of the patient to interpret
_____ provider takes the responsibility for calling on a bilingual hospital employee
_____ professional
_____ clerical
_____ custodial/food service/housekeeping
_____ facility provides volunteer interpreters
_____ facility provides paid interpreters
_____ providers use gestures
_____ provider speaks a little bit of patient's language

6. Does the facility provide in-house training for interpreters?

_____ No

_____ Yes. Please describe the training, including the content that is covered, the number of hours and for whom. _____

_____

_____

7. What sources do you call on for interpreters services? (Rank order all that apply with 1 being the method used most frequently).

_____ area language bank

_____ free lance interpreters (paid)

_____ AT & T language line

_____ outside volunteers recruited by the facility coordinator

_____ internal (on-staff) volunteers

_____ internal, paid interpreters

8. Do you screen the interpreters that the facility provides?

_____ No

_____ Yes. If yes, please describe

a) how interpreters are screened _____

_____

b) the minimum (entry-level) qualifications of a person whom you would hire as an interpreter. _____

_____

9. How much are interpreters paid at your facility?

_____ nothing

$_____ per hour

$_____ salary/year for the coordinator

$_____ salary for other staff interpreters

_____ other

10. Do bilingual staff who are called on to serve as interpreters get additional compensation for this work?

_____Yes

_____No. If no, would your facility consider paying bilingual staff who are trained as interpreters additional compensation?

_____Yes _____ No

11. How many interpreters are currently employed at your facility?

_____full-time (in what languages)_____

_____ part-time (in what languages)_____

_____other (in what languages) _____

12. Do you anticipate hiring additional interpreters during the FY95 and FY96?

_____No

_____Yes. If yes, how many and in what languages?

_____

13. For the year 2000,

a. What do you anticipate your interpreting needs to be?

b. What is your anticipated employment of interpreters?

Return this form to:

María-Paz Beltrán Avery
Education Development Center
55 Chapel Street
Newton, MA 02158-1060

Or fax to:

(617) 332-4318

or call in your answers to:

Gloryvee Hernández
(617) 969-7101 ext. 2354
outside (617) 800-225-4276

APPENDIX D
Program Competencies

Medical Interpreter Program Competencies

THE ROLE OF THE INTERPRETER

The goal of the medical interpreter role is to support the therapeutic relationship and strengthen the communication process between a provider and a patient who do not speak the same language. All three (patient, provider and interpreter) share a common interest—the health care of the patient. Given this role, the medical interpreter will be able to

1. Discuss the role of the medical interpreter, including
   - responsibilities (what they are expected to do as well as the variations of what they can do)
   - limitations (what the role is not e.g. not a patient advocate; not a "savior").
   - rights

2. Explain the possible consequences of using inappropriate interpreters.

3. Introduce themselves and their role as interpreter to the provider and the patient at the beginning of the interaction in such a way that the appropriate expectations (boundaries and limitations) are set with respect to
   - completeness
   - accuracy
   - confidentiality
   - personal limitations

4. Assess the urgency of the situation and use this assessment to decide what, when, and how to explain the role of the interpreter.

5. Assess the level of experience and openness the provider has with the role of the interpreter and use this assessment to judge when and how the role of interpreter as cultural broker is most appropriate.

6. Reassure the patient that confidentiality will be maintained at all times.

   Confidentiality means that the privacy of the patient will be maintained at all times. Confidentiality means that the interpreter will not discuss the case with other people except for professional development purposes. The interpreter has the obligation to remove all identifying information from their remarks (e.g., names of individuals, organizations, etc.) so that nothing is traceable back to the patient. In other words, the anonymity of the patient will be maintained at all times.

7. Reassure the provider that confidentiality will be maintained at all times.

8. Maintain impartiality.

Impartiality means that interpreters do not take sides nor ally themselves with either the patient or the provider. Impartiality also means that the interpreter does not advocate for a particular position or course of action. Rather, the interpreter is an advocate for a communication process that effectively bridges the language and cultural gap between provider and patient.

9. Assess their own skills, knowledge and limitations as medical interpreters.

10. Assess their own and each other's practice in a positive, constructive way in order to continue learning and reflecting on their experience.

11. Conduct themselves in a professional and ethical manner.

12. Maintain decorum and diplomacy while transmitting messages that the patient may have problems talking about (e.g., genitalia).

13. Understand that in certain situations they may be subpoenaed to appear in court.

INTERPRETATION SKILLS

1. Accurately convey everything that is said by either party to the other party.

    1.1. Convey to the provider and the patient that you will be transmitting everything that is said by either of them; therefore, they should say things as if the other person were able to understand them; anything they do not wish to have transmitted to the other person should not be said.

    1.2. Employ effective strategies for dealing with inappropriate statements, such as prejudicial remarks.

2. Describe the different methods of linguistic interpreting (e.g., simultaneous, consecutive, summary) and discuss the advantages and disadvantages of each in different circumstances.

    2.1. Use the method of consecutive interpreting effectively, using both the first person mode and the third person mode.

    2.2. Use the appropriate method given the demands of a particular situation.

3. Recognize when there is a need for clarification due to interpreter error in the choice of words or register and correct this error.

4. Recognize when there is a need for clarification on the part of the provider or patient and be able to elicit this clarification appropriately.

5. Admit they have made a mistake.

THE INTERPRETER AS CULTURAL BROKER

The medical interpreter as cultural broker will understand and be able to explain the culture of the health care setting in the United States to the patient and the cultural environment of the patient to the health care provider. As such, the medical interpreter will need to have a knowledge base in three areas: culture and language, culture and health, and cross-cultural communication.

In the area of culture and language, the medical interpreter will be able to

1. Assess the sociolinguistic register or style in which the patient is most comfortable communicating.

2. Use the linguistic register with which the patient is most comfortable.

3. Ensure that the provider describes medical concepts in a way that the patient understands what is meant.

4. Maintain the linguistic register of the patient when transforming the target language into English (in order to convey to the provider the patient's speech pattern, therefore, giving the provider enough information to decide whether or not to adjust their own speech pattern to what the patient can understand).

5. Identify and define common medical words/terms that have different meanings within a linguistic group (e.g., in Spanish, the term "fatiga").

    5.1. Check which meaning is relevant in the particular situation.

    5.2. Describe the various possible meanings these words can have.

6. Encode common medical terms and concepts interchangeably into different socio-linguistic registers or styles in both English and the target language.

    (e.g., the technical term prophylactic is called a condom in standard language and a rubber in slang. The interpreter should have this repertoire of vocabulary for the term prophylactic in both English and the target language.)

7. Use culturally appropriate words and concepts to relate biomedical terminology and concepts.

In the area of culture and health, the medical interpreter will be able to

1. Define and discuss the concept of culture, including the elements of culture (norms, beliefs, values, premises) and the processes through which cultural learning occurs (socialization, acculturation, assimilation).

    1.1. Compare and contrast the key underlying beliefs, values, norms and premises of the culture of the United States, the biomedical model, and the target culture(s).

    1.2. Compare and contrast the role of the patient (expectations, beliefs, values) and the meaning of illness in the patient's context with the role of the patient and the meaning of illness in the context of the United States.

    1.3. Compare and contrast the role of the medical provider (especially the physician) in the context of the United States with the role of the medical provider and the folk healer in the cultural context of the patient.

2. Define and discuss the non-verbal aspects of communication (space, time, kinetics, occulisics, etc.)

    2.1. Compare and contrast the non-verbal patterns associated with the culture of the United States and the target culture(s).

    2.2. Use this knowledge to assess the non-verbal messages that are being given by the patient as well as the non-verbal messages they may be inferring from the behavior of the provider.

    2.3 Use this knowledge to assess the non-verbal messages that are being given by the provider as well as the non-verbal messages they may be inferring from the behavior of the patient.

3. Recognize and discuss major folk illnesses and methods of healing and health care maintenance in the target culture(s).

4. Describe the possible effects of culture on help-seeking patterns and response to health care.

5. Discuss how cultural factors can affect diagnosis and treatment.

6. Discuss the impact of culture on the development, onset and causes of illness.

7. Identify and discuss the cultural assumptions, biases, and prejudices that guide their own personal behavior and beliefs.

In the area of cross-cultural communication, the medical interpreter will be able to

1. Identify cultural barriers to interpreting (e.g., cross-gender, age, etc.) and demonstrate knowledge of strategies to alleviate them.

2. Assess when it is appropriate to discuss with the provider, how the expectations and experiences of the patient may affect their understanding of medical concepts.

3. Convey to the provider the context in which the patient's behavior makes sense from their cultural perspective and beliefs.

4. Convey to the patient the context in which the provider's behavior make sense from their cultural perspective and beliefs

5. Assess the cultural specifics that are relevant to that particular patient given the set of circumstances that have brought them to the health care setting.

INTERPRETER AS 'COMMUNICATION PROCESS EXPERT'

The expertise that the medical interpreter brings to the triadic relationship is that of the communication process expert. The expertise that the provider brings is that of the content expert. The expertise that the patient brings is their knowledge of themselves and what it is that has brought them to the health care setting. The interpreter must remember that the patient should always retain control of the decisions that affect them.

As the communication process expert, the medical interpreter will be able to

1. Structure the process of communication (the exchange of information) between the provider and the patient so that it occurs effectively and accurately.

    1.1. Place themselves physically in relation to the provider and the patient in a way that promotes direct interaction between the patient and the provider.

2. Mediate turn-taking behavior
    - to ensure accuracy
    - to ensure a normal sense of give and take between provider and patient
    - that is culturally sensitive to the unspoken rules of how and when to interrupt whom

    2.1. Constructively stop the process when necessary to make sure that the provider and the patient are in fact communicating with each other towards their shared goal—the health care of the patient.

    2.2 Assess when to stop the provider in order to raise the provider's awareness of cultural issues that may be interfering.

    2.3. Assess when the message is not being communicated (by recognizing non-verbal cues, speech patterns) from one party to the other.

3. Assess whether a need for clarification on the part of the patient or the provider is due to interpreter error (i.e., in their choice of words, register, etc.) or vagueness on the part of the speaker.

4. Ensure that all information is always shared both ways.

5. Use the appropriate intervention strategy (or strategies) to ensure that communication is occurring (e.g., knowing what questions to ask and how to phrase them so that the intervention is useful to both)

6. Ensure that the patient knows they have the right to ask and be comfortable asking questions of the provider or the interpreter.

7. Assist each party to take responsibility for any contradictory and/or controversial information they may give.

MEDICAL CONCEPTS:

1. Medical interpreters will have a working knowledge of the basic anatomy of the human body. In both English and the target language, they will be able to

    1.1. Name and identify the major parts of the human body (i.e., organs, major body cavities).

    1.2. Name and identify the parts of the body systems (i.e., skeletal, muscular, cardiovascular, lymphatic and immune system,respiratory system, digestive system, urinary system, nervous system, endocrine system, reproductive systems, integumentary system).

    1.3. Describe the functions of the major systems of the body.

    1.4. Discuss the concept of pathology/disease, the common causes of pathology and their transmission (i.e., environmental, viral, bacterial, genetic, congenital, parasitic, poisoning, intoxication and substance abuse, sexual transmission).

    1.5. Identify and describe commonly occurring illnesses or presenting syndromes in the target cultural/linguistic group (e.g., asthma, parasitic infections).

    1.6. Discuss contemporary public health issues related to human physiology and anatomy.

2. Medical interpreters will have a basic knowledge of general medical terminology. In both English and the target language, they will be able to

    1.1. Define medical terms by analyzing the structure of the term according to roots, suffixes and prefixes (e.g., it is).

    1.2. Identify, describe and explain the functions of major diagnostic and imaging procedures, and treatment procedures (diagnostic/imaging: e.g., laboratory procedures, imaging tools such as X-rays, scans, and ultrasounds, MRI, biopsies; treatments: (e.g., intravenous treatments, intubations, cauterizations, oral treatments).

3. Relate major pathologies to major treatments.

HEALTH CARE SYSTEMS AND ORGANIZATIONAL STRUCTURES

1. Medical interpreters will have a working knowledge of the health care system in Massachusetts. In both English and the target language, they will be able to

    1.1. Name and explain different delivery systems and resources in Massachusetts (HMOs, private practice, public institutions, special programs such as Health Start, WIC, health care for the homeless, hospitals, clinics, long-term care facilities)

    2.2. Name and explain how to access health care services in Massachusetts (i.e., Medicare, Medicaid, free care, private insurance, SSI)

2. Medical interpreters will have a working knowledge of the 'generic' medical and non-medical organizational structures (e.g. departments) and protocols of health care facilities in the United States. They will be able to

    2.1. Explain the functions of major departments. (e.g., emergency/trauma, intensive care, maternity, pediatrics, nursing, radiology, patient representative, administration, etc.).

    2.2. Explain major hospital protocols (informed consent, patient bill of rights, living wills, organ donation, birth certificates, proxy, admission procedures, discharge procedures, grievance procedures).

    2.3. Describe the major health care provider roles (e.g., physician, registered nurse, licensed practical nurse, internist).

    2.4. Demonstrate awareness of legal issues in health care (e.g., malpractice, mandated reporting in cases of child abuse, etc.).

COMMUNICATION SKILLS

1. Demonstrate effective listening strategies.

2. Demonstrate an ability to concentrate under distracting conditions.

3. Demonstrative effective memory enhancing strategies.

4. Demonstrate the ability to use, in both languages, common communication functions (e.g., interrupting, correcting misunderstandings, giving/responding to feedback, asking for meaning, etc.)

INTERPRETER AS TEAM MEMBER

1. Understand the dynamics of power and control in the triadic interpreting relationship.

    1.1. Maintain a low profile in the interaction, by their physical placement of themselves, their tone of voice.

    1.2. Respect the role of the provider as the technical, content expert.

    1.3. Support the patient in their right to ultimate control over the decisions that affect them.

2. Structure the physical space and the placement of each party in the triad so as to maximize the direct communication between provider and patient.

APPENDIX E
Language Assessments

MEDICAL INTERPRETER PROGRAM

Language Assessment
Spanish

Name_____

Date_____

Please read and follow the instructions for each section very carefully. While most of the instructions are written in English, your answers, unless otherwise indicated, should be in Spanish. Make sure you complete every page in this assessment instrument.

Oral:

This part of the assessment will be taped and kept in your file. At the start of your taping **PLEASE STATE YOUR NAME CLEARLY INTO THE TAPE RECORDER.** Please leave the tape recorder on while doing the oral part of the assessment. Do not turn it off until you start the written part.

A. Please **speak in Spanish**. Make sure that your answers are at least two (2) minutes long. It is preferable that you speak longer than two minutes rather than less than two minutes.

1. Tell us a little bit about yourself. For example, where did you and your family come from?
   - When did you come to the United States?
   - What were your experiences like when you first arrived?
   - If your were born in the United States, how did you learn Spanish?
   - Have you lived in a country or community where Spanish is used as a medium of communication on a regular basis? Give examples of some of your experiences in that community.
   - What kinds of things are you interested in?
   - What are you currently doing?

2. In your opinion, what are some of the dangers of using inappropriate or untrained interpreters such as family members, children, or neighbors, in the medical setting? Give examples of experiences you might have had or heard about.

Name _____

B. Following is a list of words in Spanish that are commonly used in the medical setting. For each word

- Say the word in Spanish
- Give the English equivalent
- Explain what the word means in Spanish

1. escalofrío
2. diarrea
3. vacuna
4. anticonceptivo
5. parásito
6. fatiga
7. aborto
8. termómetro
9. calambre
10. vejiga

Name _____

C. Say the following in **Spanish**.

1. Your high blood pressure will not go down if you keep eating too many salty foods.

2. When did you first notice that lump in your breast?

3. Do you notice the shortness of breath even when you are sitting down?

4. What kind of headache do you get? Is it a dull pain or a constant throbbing?

5. You said that the vaginal discharge you have does not smell.

6. Did your child have a high temperature last night?

7. The medication will be given to you intravenously.

8. If you have a recurrence of these symptoms before you get to see your own doctor, make sure you return to the emergency room for emergency treatment.

9. The electrocardiogram taken shows that you may have had a small heart attack. I would like to have you admitted to the hospital as a precaution.

10. I see here in your previous history that you've never been short of breath when exercising, have slept on one pillow all your life, never had swelling of the ankles, nor had to get up during the night to urinate. Is that all correct?

TURN OFF THE TAPE RECORDER WHEN YOU FINISH THIS SECTION.

Name _____

Written : Please answer the following questions in Spanish. Make sure you write at least ten (10) complete sentences for each answer.

A. Explique su interes en este programa. Porqué quiere ser interprete medico?

Name _____

B. Escriba sobre una experiencia personal que usted siente ha tenido una gran influencia en su vida.

MEDICAL INTERPRETER PROGRAM

Language Assessment
Khmer

Name_____

Date_____

Please read and follow the instructions for each section very carefully. While most of the instructions are written in English, your answers, unless otherwise indicated, should be in Khmer. Make sure you complete every page in this assessment instrument.

Oral:

This part of the assessment will be taped and kept in your file. At the start of your taping PLEASE STATE YOUR NAME CLEARLY INTO THE TAPE RECORDER. Please leave the tape recorder on while doing the oral part of the assessment. Do not turn it off until you start the written part.

A. Please **speak in Khmer**. Make sure that your answers are at least two (2) minutes long. It is preferable that you speak longer than two minutes rather than less than two minutes.

1. Tell us a little bit about yourself. For example, where did you and your family come from?
   - When did you come to the United States?
   - What were your experiences like when you first arrived?
   - If your were born in the United States, how did you learn Khmer?
   - Have you lived in a country or community where Khmer is used as a medium of communication on a regular basis? Give examples of some of your experiences in that community.
   - What kinds of things are you interested in?
   - What are you currently doing?

2. In your opinion, what are some of the dangers of using inappropriate or untrained interpreters such as family members, children, or neighbors, in the medical setting? Give examples of experiences you might have had or heard about.

Name_____

B. Following is a list of words in Khmer that are commonly used in the medical setting. For each word

- Say the word in Khmer
- Give the English equivalent
- Explain what the word means in Khmer

1- ...

2. ...

3 - ...

4 - ...

5 - ...

6 - ...

7 - ...

8 - ...

9 - ...

10 - ...

Name_____

C. Say the following in **Khmer**.

1. Your high blood pressure will not go down if you keep eating too many salty foods.

2. When did you first notice that lump in your breast?

3. Do you notice the shortness of breath even when you are sitting down?

4. What kind of headache do you get? Is it a dull pain or a constant throbbing?

5. You said that the vaginal discharge you have does not smell.

6. Did your child have a high temperature last night?

7. The medication will be given to you intravenously.

8. If you have a recurrence of these symptoms before you get to see your own doctor, make sure you return to the emergency room for emergency treatment.

9. The electrocardiogram taken shows that you may have had a small heart attack. I would like to have you admitted to the hospital as a precaution.

10. I see here in your previous history that you've never been short of breath when exercising, have slept on one pillow all your life, never had swelling of the ankles, nor had to get up during the night to urinate. Is that all correct?

<u>TURN OFF THE TAPE RECORDER WHEN YOU FINISH THIS SECTION.</u>

Name_____

Written : Please answer the following questions in Khmer. Make sure you write at least ten (10) complete sentences for each answer.

A) តើមូលហេតុអ្វីបានជាអ្នកមកប្រឡងចូលរៀនក្នុងកម្មវិធីនេះ?

សូមអធិប្បាយដោយសង្ខេប

Name_____

ខ) សរសេរអំពីប្រវត្តិរបស់អ្នកផ្ទាល់ចាប់តាំងពីពេលចេញពីស្រុកខ្មែររហូតមកដល់សព្វថ្ងៃនេះ។

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MEDICAL INTERPRETER PROGRAM

Language Assessment
Vietnamese

Name_____

Date_____

Please read and follow the instructions for each section very carefully. While most of the instructions are written in English, your answers, unless otherwise indicated, should be in Vietnamese. Make sure you complete every page in this assessment instrument.

Oral:

This part of the assessment will be taped and kept in your file. At the start of your taping **PLEASE STATE YOUR NAME CLEARLY INTO THE TAPE RECORDER.** Please leave the tape recorder on while doing the oral part of the assessment. Do not turn it off until you start the written part.

A. Please **speak in Vietnamese**. Make sure that your answers are at least two (2) minutes long. It is preferable that you speak longer than two minutes rather than less than two minutes.

1. Tell us a little bit about yourself. For example, where did you and your family come from?
   - When did you come to the United States?
   - What were your experiences like when you first arrived?
   - If your were born in the United States, how did you learn Vietnamese?
   - Have you lived in a country or community where Vietnamese is used as a medium of communication on a regular basis? Give examples of some of your experiences in that community.
   - What kinds of things are you interested in?
   - What are you currently doing?

2. In your opinion, what are some of the dangers of using inappropriate or untrained interpreters such as family members, children, or neighbors, in the medical setting? Give examples of experiences you might have had or heard about.

Name_____

B. Following is a list of words in Vietnamese that are commonly used in the medical setting. For each word

- Say the word in Vietnamese
- Give the English equivalent
- Explain what the word means in Vietnamese

1. Cổ Thể =
2. Bệnh Siểng =
3. Xương Sống =
4. Bệnh Ung Thư =
5. Thận =
6. Thần Kinh =
7. Mang Thai =
8. Bắp Thịt =
9. Bệnh Sốt Rét =
10. Tiêu Chảy = .

Name_____

C. Say the following in **Vietnamese**.

1. Your high blood pressure will not go down if you keep eating too many salty foods.

2. When did you first notice that lump in your breast?

3. Do you notice the shortness of breath even when you are sitting down?

4. What kind of headache do you get? Is it a dull pain or a constant throbbing?

5. You said that the vaginal discharge you have does not smell.

6. Did your child have a high temperature last night?

7. The medication will be given to you intravenously.

8. If you have a recurrence of these symptoms before you get to see your own doctor, make sure you return to the emergency room for emergency treatment.

9. The electrocardiogram taken shows that you may have had a small heart attack. I would like to have you admitted to the hospital as a precaution.

10. I see here in your previous history that you've never been short of breath when exercising, have slept on one pillow all your life, never had swelling of the ankles, nor had to get up during the night to urinate. Is that all correct?

<u>TURN OFF THE TAPE RECORDER WHEN YOU FINISH THIS SECTION.</u>

Name_____

Written : Please answer the following questions in Vietnamese. Make sure you write at least ten (10) complete sentences for each answer.

1. Tại sao bạn muốn trở thành Thông Dịch Viên nghành Y khoa ?

Name_____

2. Xin diễn tả một kinh nghiệm cá nhân mà bạn cảm thấy rất có ý nghĩa đối với bạn.

Rating Form
for
Language Proficiency

Name of applicant _____ Date _____

Name of rater _____ Date _____

Language _____

A. EXPRESSIVE LANGUAGE (Use all the samples from the oral section of the Language Assessment Tool to complete I-IV.)

I. General Speed of Speech (Fluency) and Sentence Length

____ 3. Speech speed and sentence length are those of a native speaker.

____ 2. Speed of speech seems to be slightly affected by language problems.

____ 1. Speed of speech and length of utterance are strongly affected by language difficulties and limitations

____ 0. Speech is so halting and fragmentary, as to make conversation with "the person in the street" almost impossible

II. Vocabulary

____ 3. Use of vocabulary and "idioms" is virtually that of a native speaker.

____ 2. Sometimes uses inappropriate terms and/or round-about language because of inadequate vocabulary.

____ 1. Frequently uses the wrong words; speech limited to simple vocabulary.

____ 0. Vocabulary is inadequate; words are misused such that comprehension is quite difficult.

III. Grammar and Word-Order

____ 3. Uses the language with few (if any) noticeable errors of grammar and word order.

____ 2. Meaning occasionally obscured by grammatical and/or word-order errors.

____ 1. Frequently needs to rephrase construction and/or restricts himself to basic structural patterns (e.g., uses the simple present tense where the past or future tense should be used).

____ 0. Speech so full of grammatical and word-order errors as to be almost unintelligible to "the person in the street."

IV. Pronunciation (including word accent and sentence pitch)

____ 3. Speaks with few (if any) traces of a "foreign accent."

____. 2. "Foreign accent" necessitates concentrated listening and leads to occasional misunderstanding. Words and sentences must sometimes be repeated.

____ 1. Many serious errors in pronunciation. Very hard to understand because of sound, accent, pitch difficulties.

____ 0 Pronunciation would be almost unintelligible to "the person in the street."

B. COMPREHENSION OF ORAL LANGUAGE (Complete this section only after a face-to-face interview is conducted with the applicant in the language of choice.)

V. Oral Comprehension

____ 3. Understands everything; minor or no adjustments in speed or vocabulary are needed.

____ 2. Understands fairly well at normal or slightly slower-than-normal speed. Sometimes needs repetition.

____ 1. Has trouble understanding; frequent adjustments in speed and vocabulary are necessary. Frequent repetition necessary.

____ 0. Cannot be said to understand even simple conversations.

Total Rating (A and B) _____ (15 possible points)

C. **WRITTEN LANGUAGE** (Use the samples from the written section of the Language Assessment Tool to complete this rating.)

____ 3. Can express themselves clearly in writing, using complex grammatical structures .

____ 2. Can express themselves in writing using simple sentences; spelling errors do not affect intelligibility; the text can be understood.

____ 1. Has trouble expressing themselves in writing; incorrect use of grammatical forms and misspelling make the text difficult to understand.

____ 0 Cannot write a simple sentence that is intelligible.

Total Rating (Section C) _____ (3 possible points)

D. **COMMENTS AND RECOMMENDATIONS**

(Adapted from: The American Language Institute, Georgetown University. Washington. D.C. 1962.)

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APPENDIX F
DACUM Analysis

DUTY A:INTERPRETING	A-1 Work in a variety of settings and conditions (ER, OR, Social Services, Stress Lab...)	A-2 Prioritize tasks	A-3 A Prioritize and respond to calls promptly	A-3 B Manage time	A-4 Asses and adapt to "comfort" needs of patient regarding interpreters age, gender and other potential sources of conflict
	A-12 Listen understand, convert, re-express the message (SL—TL) preserving content, function, register, affect and content.]	A-13 Manage the flow of information/ communication	A-14 Select and employ appropriate mode (s) (simultaneous, consecutive, summary; 1st or 3rd person)	A-15 Take notes	A-16 Keep patient /family/provider calm and well-informed
	A-24 Complete closure activities	A-25 Follow-up as necessary	A-26 Complete appropriate documentation	A-27 Provide verbal instructions via audiotape of individual patient instructions	A-28 Provide written translation of instructions given in writing by provider for the individual patient
DUTY B: CULTURAL BROKER	B-1 Employ techniques to respect domains of power (provider, patient, interpreter	B-2 Promote understanding among cultures, health belief systems	B-3 Use culturally appropriate language and terminology	B-4 Encourage patient/provider ability to communicate together	B-5 Prompt provider/patient to search for ways to deal with the issue
	B-13 Promote access to health services to diverse cultures	B-14 Inform/ educate community /individuals on medical system and practices in the U.S.	B-15 Educate on cross cultural issues related to the patient	B-16 Learn about / use the natural support system existing in the cultural community	B-17 Network with colleagues, medical providers, traditional healers, religious and community leaders
DUTY C: ETHICS	C-1 Maintain confidentiality	C-2 Respect patient's privacy	C-3 Respect patient's rights	C-4 Deal with discrimination, neglect and other issues	C-5 Ensure your understanding and convey the intent of each speaker and purpose of the message
	C-13 Refrain from contact with patient outside scope of employment which results in personal benefit				
DUTY D: PROFESSIONAL DEVELOPMENT/TRAINING	D-1 Learn/apply policies/procedures of place (s) of employment	D-2 Maintain glossary of terms (dialect variations, medical terms)	D-3 Take courses	D-4 Read literature of the field (journals/ periodicals)	D-5 Participate in seminars, workshops, training
DUTY E: DOCUMENT	E-1 Follow organizational policies/ procedures	E-2 Invoice/bill clients	E-3 Attest to delivery of interpreter services by signature	E-4 A Maintain files	E-4 B Keep logs

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A-5 Hold pre/mid or post conference with provider (goal, roles, procedures)	A-6 Assess patient (language, accent, dialect)	A-7 Introduce self explain role	A-8 Assure patient and provider of confidentiality completeness and accuracy	A-9 Suggest seating/standing configuration	A-10 Encourage direct communication between patient and provider	A-11 Accurately transmit information between patient and provider
A-17 Manage dynamics of the triad	A-18 Manage conflict	A-19 Remain calm in stressful situations	A-20 Ensure that the message is understood	A-21 Self-check accuracy of interpretation/ correct as needed	A-22 Ask for clarification as needed	A-23 Ensure concerns raised during or after interview are addressed/ referred to the appropriate resource
A-29 Provide written translation of instructions given verbally by provider for the individual patient	A-30 Appear as a court witness when necessary					
B-6 Recognize/ identify discrepancies between cultures and belief systems	B-7 Assess impact of discrepancies on understanding of the message and patients decision to follow-through on treatment plan	B-8 Make judgments on understanding of communications	B-9 Assess/determine the appropriate time to raise the issue	B-10 Determine the appropriate method (how to raise issue)	B-11 Verbalize cultural issues	B-12 Provide relevant information
B-18 Educate community on role of interpreter and how to access medical and interpreter services						
C-6 Interpret accurately and completely with out omitting, modifying or condensing	C-7 Maintain impartiality	C-8 Refrain from counseling, advising, and/or interjecting personal opinions	C-9 Maintain professional "distance" (physical and emotional) from patient	C-10 Refrain from accepting or withdraw from assignments for which you cannot interpret accurately or impartially (e.g.: limitations of skill/knowledge, conflict of interest, strong personal beliefs)	C-11 Ask for clarification/ information	C-12 Respect the domains of power in the triadic relationship
D-6 Participate in professional organizations	D-7 Share information and resources	D-8 Orient new personnel to role of interpreter and how and when to discuss services	D-9 Give workshops seminars, speeches			
E-5 Enter information on computer	E-6 Write reports	E-7 Complete forms				

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DUTY F: COORDINATING/ MANAGING SERVICES	F-1 Design/develop/ implement/ monitor/ recommend policy— procedures	F-2 Design Medical Interpreting service delivery system	F-3 Maintain a roster of free-lance medical interpreters	F-4 Maintain roster of medical providers who speak a language other than English	F-5 Develop and maintain a working team relationship with appropriate staff in workplace
	F-13 Process payment for Medical Interpreter services	F-14 Maximize cost effectiveness of services	F-15 Maintain files and records	F-16 Write reports	F-17 Develop/ monitor budget
DUTY G: FREELANCE WORK	G-1 Respond to calls	G-2 Organize transportation	G-3 Maintain a schedule/log of services	G-4 Establish mechanism for accessibility	G-5 Schedule appointments
	G-13 Make recommendations to interpreting services	G-14 Maintain a file of agencies needing Medical Interpreter services	G-15 Refer customers to other interpreters when appropriate	G-16 Market Medical Interpreting services	

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F-6 Handle problem situations	F-7 Assess and project need for interpreter services	F-8 Assess skills of potential volunteer interpreters	F-9 Handle personnel: recruit/ select/ supervise/ evaluate/train/ orient/hire/fire	F-10 Monitor interpreter services	F-11 Provide medical interpreters with support needed to handle stressful and emotionally charged work situations	F-12 Promote professional development of interpreters
F-13 Schedule Medical interpreter sessions	F-19 Develop cooperative agreements with other departments	F-20 Create internship opportunities	F-21 Maintain file of agencies/ resources who offer supportive services	F-22 Find funding sources for related projects		
G-6 Follow policies/ procedures of workplace (s)	G-7 Develop and maintain a working team relationship with appropriate staff in workplace	G-8 Seek support and help from appropriate hospital staff	G-9 Maintain accounting/ bookkeeping records as a self-employed individual	G-10 Invoice/ bill customers	G-11 Design Medical Interpreter delivery of freelance services	G-12 Maximize cost effectiveness of services

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ATTRIBUTES

Think on their feet

Maintains a professional demeanor

Be creative in expression

Likes people

Desire to help people

Attentive

Diplomatic

Ethical

Honest

Speaks clearly

Can see more than one point of view

Able to differentiate between own ideas and the idea/beliefs, bias, emotions of those for whom you are interpreting

Able to perceive and acknowledge feelings of others

Comfftable with simultaneously holding different conflicting opinions at same time

Tolerance for blood, trauma

Calm in face of crisis and adversity

Ability to perform in high-risk, stressful situations e.g.: trauma unit, ER, OR

Impartiality

Positive attitude

Self motivated

Good memory

Ability to concentrate

Flexible

Punctual

Discrete

Good hearing

Comfortable not being the "center" of attention

Curiose

Understands variety of accents (skill)

Able to follow directions

Assertive

Integrity

Patience

Detail oriented

Reliable

KNOWLEDGE (know)

Knows own limitations

Proficient in English and other language

Able to express subtle shades of meaning

Different ways of expressing the same thing

Able to understand language at first hearing

Understand transference and counter transference

Dynamics of grief and loss—death and dying

Medical systems and hierarchy

Process of acculturation

Medical terminology

Variety of accents

Group dynamics

Interpreting techniques:

- simultaneous
- consecutive
- summary
- mnemonic devices
- notetaking
- interrupting speaker
- sight translation
- visualizing
- memory building
- recognize propositions

Medical procedures

Health care systems (local, state and national)

Greek/Latin prefix/suffix

Medical abbreviations

Patient's rights

Ethical issues

Implications of informed consent

Basic anthropology

Social services

Applied linguistics (parameters of meaning, structure of language)

Types of interpreter error

Know organization of community

Locating resources

Time management

Networking

Cross-cultural communication

Non-verbal communication

Culturally appropriate language/terminology /Body language

Design delivery system

Filing

Bookkeeping/accounts

Phone skills

Write reports

Collect data

Analyze statistics

Public speaking

Proposal development

Funding sources

Evaluation (self evaluation) techniques

Give/receive feedback

Supervision

Personnel

Know appropriate attire

Conflict resolution

Negotiation/mediation

Organizational skills

Budget skills

Questioning techniques

Prioritize

Professional etiquette

Analytic skills

Knowledge of safety issues

Problem solving skills

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Anatomy and Physiology/Pathology

Legal issues and liabilities

Organ donation and tissue donations/policies

Epidemiology prevalent in population interpreting for

Knowing where to find information

Know key health beliefs, values, etc. for patient's culture and medical culture

TOOLS

telephone conference calls

maps and directions

beeper

watch

computer

"flash cards"

dictionaries, reference materials

video and audio tapes

microphones

overhead projector

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APPENDIX G
Standards of Practice

Medical Interpreters Standards of Practice

Massachusetts Medical Interpreters Association

Massachusetts Medical Interpreters Association
and
Education Development Center, Inc.
October 1995

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To Raquel Cashman,
friend and colleague,
whose concern for excellence,
justice and harmony guides this work

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INTRODUCTION

The primary function of the medical interpreter is to make possible the communication between a health care provider and a patient who do not speak the same language. In performing this function, the medical interpreter's commitment is to the goals of the clinical interview. The presence of an interpreter makes it possible for the patient and provider to achieve the goals of their encounter as if they were communicating directly with each other.

Using a third person to communicate between providers and patients who do not speak the same language has been going on for a long time. Unfortunately, however, this practice has been fraught with many misconceptions about the nature of interpreter-mediated communication. One of the most common misconceptions is that anyone who is bilingual, at any level of bilinguality, is capable of providing effective interpretation. Thus we see the continued use of children, family members, and auxiliary staff (e.g., clerical, custodial, housekeeping) as interpreters. However, even equal levels of fluency in two languages is only a necessary and not a sufficient skill in interpreting. In addition, an interpreter must be able to convert messages uttered in one language into the appropriate sociolinguistic framework of another language. And, unlike conference interpreting, in which an interpreter converts only into one language, the medical interpreter must be able to make the conversion from and into two languages.

Another common misconception is that communication in health care settings is a relatively simple task in which much of the information can be gathered by "scientific, objective" means and much of the meaning can be conveyed by gestures (de Jongh, 1992). The reality is that the clinical interview relies heavily on language for much of its information gathering.

These misconceptions are further exacerbated when the parties most affected by the interpretation lack the skills to judge its quality. Neither the patient nor the provider can monitor the accuracy and completeness of the interpretation since each speaks only one of the languages. Neither has a way of knowing whether the interpreted message they received contained omissions, additions, interpreter opinions, guesses, or other distortions that could result in serious miscommunication.

It is for these reasons that standards of practice in medical interpretation are critical. Standards of practice provide a defining baseline of expectations for consumers and practitioners. They provide a measure against which individual

interpreters can monitor the quality of their own performance. They establish criteria for certification and/or entry into the profession, ensuring quality and consistency of performance.

The Development Process

The standards of practice presented here were developed through the use of a modified DACUM (Developing a Curriculum) process. The DACUM process is a method of occupational analysis for professional and technical jobs. Through this process, expert workers are engaged in describing and defining the tasks that comprise their job, including the specific knowledge, skills, tools, and attitudes needed to perform these tasks correctly.

Twelve experienced medical interpreters, members of the Massachusetts Medical Interpreters Association (MMIA), met in a two-day workshop with a DACUM facilitator to generate the universe of major duties, responsibilities, and tasks performed within their medical interpreter roles. The group was composed of coordinators of interpreter services, staff interpreters, and freelance interpreters, representing six linguistic groups. Each had at least three years' paid experience at major teaching hospitals, community health centers, and/or other health facilities. The data compiled covered a broad range of tasks, reflecting the different positions held by the members of the group. Thus, in addition to those tasks specific to the interpreting encounter itself, broader duties such as educating consumers on the use of interpreters, setting up delivery systems, and billing for services were also included. Using this data as a foundation, the Subcommittee on Standards of Practice of the MMIA then developed standards of practice focusing only on the competencies specific to the interpreting encounter.

In developing these standards of practice, the subcommittee faced a major challenge: setting standards that upheld excellence in the accuracy and completeness of interpretation while responding to the immediate, urgent need for interpreters within linguistic groups in which the number of individuals proficient in both English and another language is limited. This challenge was met by differentiating between two types of skills: linguistic proficiency and interpreting skills. Once this distinction was made, it was possible to conceptualize and define a broad range of interpreting skills that could be used as strategic interventions to ensure accuracy and completeness while accommodating differing levels of linguistic proficiency. Thus, at one end of the linguistic continuum are those individuals whose mastery of the two languages is such that they have a breadth of understanding of the

content that they have little need to interrupt the speakers, whether for retention or clarification, and a depth of knowledge of linguistic variations that they have little need to pause to search for the appropriate form of expression. At the other end of the continuum are those individuals who are somewhat more limited in their level of comprehension and depth of expression. However, with supportive skills such as asking for clarification, managing the flow of communication, and with an awareness of their personal limitations, the interpreter can maintain accuracy and completeness in their interpretations.

THE MEDICAL INTERPRETER STANDARDS OF PRACTICE

The Medical Interpreter Standards of Practice are founded on the premise that an interpreter's primary task is interpretation; that is, the transmission of a message expressed in a source language to its equivalent in a target language, so that the interpreted message has the potential for eliciting the same response in the listener as the original message (Seleskovich, 1978; Cokely, 1988; Downing and Swabey, 1992). To be able to do this, the interpreter must not only be fluent in the two languages but must also have the skills and knowledge base to be able to quickly comprehend the message in the source language and just as quickly re-express it in the target language.

If all that the provider and patient need to achieve the goals of the clinical encounter is this linguistic conversion, then the fulfillment of the interpreter's role is to provide such a conversion. These standards, however, go beyond the skills of conversion and recognize the complexities of interpretation and the clinical interview. The medical encounter is a highly interactive process in which the provider uses language (theirs and the patient's) as a powerful tool to understand, evaluate, and diagnose symptoms (Woloshin, et. at., 1995), and to mutually inform and instruct. The interpreter, therefore, cannot simply be a "black box converter" but must know how to effectively and efficiently engage both provider and patient in accessing the nuances and hidden sociocultural assumptions embedded in each other's language, which could lead to dangerous consequences, if left unexplored.

These standards of practice also recognize the importance of the medical encounter in establishing a therapeutic connection between provider and patient. Establishing a therapeutic relationship is especially difficult when parties cannot communicate directly and becomes even more complex when different culturally based belief systems are involved. A competent interpreter can mediate these

barriers by attending not only to the linguistic but also to the extra- linguistic aspects of communication.

The Medical Interpreter Standards of Practice are organized into three major task areas: (A) Interpretation, (B) Cultural Interface, and (C) Ethical Behavior. Following is a brief explanation of each of these task areas.

A. Interpretation

As noted earlier, the primary task of the interpreter is to interpret; that is, to convert a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if they had heard it in the original (Seleskovitch, 1978; Cokely, 1988; Downing and Swabey, 1992). Equivalence, however, does not mean a literal or word-for-word conversion from one language into the other. Rather, it requires an analysis of the original message in order to render the fullness of its meaning in another language (Seleskovich, 1978; Isham, 1985). The primary test of a competent interpreter, therefore, is the accuracy and completeness of their interpretation.

Although interpreting is the main task of the interpreter, there are other complementary skills that an interpreter must have, although they are not necessarily used in every encounter. The standards of practice in this section focus on both the skills of interpreting as well as these complementary skills. The skills in this section can be organized around five subtasks:

1. *Setting the Stage.* The role of the professional interpreter is still new and largely unknown in the medical setting. For this reason, it is important that the interpreter set clear expectations for their role at the very start of the triadic (provider-patient-interpreter) encounter, stressing in particular the elements of accuracy, completeness, and confidentiality from the very beginning. It is also important for the interpreter, in the early moments of the triadic encounter, to attend to other concerns such as arranging the spatial configuration of the parties in the encounter, addressing any discomfort a patient or provider may have about the presence of an interpreter, or assessing the linguistic style of the patient, keeping in mind, at all times, the goal of establishing a direct relationship between the two main parties.
2. *Interpreting.* The most basic task of the interpreter is to transmit information accurately and completely. Therefore, the interpreter must operate under a dual commitment: (1) ensuring that they fully understand the message in the source language, and (2) retaining the essential elements of the communication in their

interpretation into the target language. Interpreters whose linguistic proficiency (in terms of breadth and depth) in both languages is very high and who have a solid working knowledge of the subject matter, are more likely to be able to make the conversions from one language to another without needing to ask for much clarification. For those whose linguistic proficiency is limited, the use of appropriate strategies can ensure that they themselves understand the message before they make the conversion and that all the pertinent information has been transmitted.

3. *Managing the Flow of Communication.* In the interests of accuracy and completeness, the interpreter has to be able to manage the flow of communication so that important information is not lost or miscommunicated. At other times, the interpreter may have to attend to the dynamics of the interpersonal interaction between provider and patient, for example, when tension or conflict arises. The role of the interpreter, however, is not to take responsibility for the actions of the two parties but rather to assist in establishing a communication process that allows the parties to work things out for themselves.
4. *Managing the Triadic Relationship.* The introduction of a third party into the medical encounter generates dynamics that are inherent to triadic interactions. A primary characteristic of a triadic relationship that is absent from the dyadic is the potential for the formation of alliances between two of the parties. Because the interpreter is the party to whom both provider and patient can relate most directly, there is a propensity to want to form an alliance with the interpreter. This is often evidenced by provider and patient directing their remarks to the interpreter rather than to each other and leads to the "tell the patient/doctor" form of communication. Thus, the interpreter must work at encouraging the parties to address each other directly, both verbally and nonverbally.

The natural tendency of both provider and patient is to perceive the interpreter as an extension, either of their own world or that of the other, and not as a partner in their own right, with their own role responsibilities and obligations. On the part of the patient, the desire to form an alliance with the interpreter is heightened because they are likely to perceive the interpreter as understanding not only their language but also their culture. This perceived cultural affinity often leads the patient to act as if the interpreter were there as their friend and advocate. On the part of the provider, the danger in assuming that the interpreter is part of their world is that they may expect that the interpreter can and should take on other

functions, such as obtaining a medical history. On the other hand, when providers assume that interpreters are extensions of the patient's world, the tendency is to dismiss the importance of the role and ascribe inferior status to the work of the interpreter.

As a professional in their own right, the interpreter's aliegiance in the interpreter-mediated encounter is to the therapeutic relationship and its goal of quality health care. The commitment of the interpreter is to support the other two parties in their respective domains of expertise, that is, the provider as the "technical expert" with the knowledge and skills in medicine and health care, and the patient as the "expert" on themselves, their symptoms, beliefs and needs. The provider offers informed opinions and options, while the patient remains the ultimate decision-maker for themselves. The role of the interpreter is not to take control of the substance of the messages but rather to manage the process of communication.

5. *Assisting in Closure Activities.* The responsibility of the interpreter, in the closing moments of the clinical encounter, is to encourage the provider, when necessary, to provide follow-up instructions that the patient understands and will therefore be more likely to follow. In addition, the role of the interpreter is to make sure that the patient is connected to the services they need (including additional interpreter services) and to promote patient self-sufficiency, taking into consideration the social context of the patient.

B. Cultural Interface

Language is not the only element at work in the interaction between providers and patients who speak different languages. The meaning inherent in the messages conveyed is rooted in culturally based beliefs, values, and assumptions. According to the linguists Whorf (1978) and Sapir (1956), language is an expression of culture and the ways in which culture organizes reality. The interpreter, therefore, has the task not only of knowing the words that are being used but of understanding the underlying, culturally based propositions that give meaning to the words of the speaker in the context in which they are spoken. Interpreting in the health care arena requires that the interpreter understand the ways in which culturally based beliefs affect the presentation, course, and outcomes of illness, as well as perceptions of wellness and treatment.

If provider and patient share similar assumptions about medicine and its positivistic, scientific principles, it is more likely that the interaction will go as

smoothly as if they were speaking the same language. In such a case, the interpreter would simply have to make the conversion from one linguistic system into the other and the layers of meaning would be understood.

As the dissimilarities between provider and patient increase, however, literal interpretations become inadequate, even dangerous. In such cases, in order for the intent of the message to be accurately and completely conveyed, it may be necessary to articulate the hidden assumptions or unstated propositions contained within the discourse. Here the role of the interpreter is to assist in uncovering these hidden assumptions and, in doing so, to empower both patient and provider with a broader understanding of each other's culture.

Another major cultural linguistic problem occurs when "untranslatable" words are used by a speaker. "Untranslatable" words represent concepts for which a comparable referent does not exist in the society using the target language (Seleskovitch, 1978). For example, the concept of bacteria, a living physical organism that is not visible to the naked eye, is a concept that has no equivalent in many rural, nonliterate societies. In order to get the concept across, the interpreter may have to work with the provider to find ways to transmit the essential information underlying this concept.

The interpreter, therefore, has the task of identifying those occasions when unshared cultural assumptions create barriers to understanding or message equivalence. Their role in such situations is not to "give the answer" but rather to assist both provider and patient to investigate the intercultural interface that may be creating a problem. The interpreter must keep in mind that no matter how much "factual" information they have about the beliefs, values, norms, and customs of a particular culture, they have no way of knowing where the individual facing them in that specific situation stands along a continuum from close adherence to the norms of a culture to acculturation into a new culture. Cultural patterns, after all, are generalized abstractions that do not define the individual nor predict what an individual believes or does. Cultural patterns are simply hypotheses of the greater likelihood of their occurrence in a member of that culture than in someone who is not a member (Avery, 1992).

C. Ethical Behavior

The role of interpreter, on the surface, appears to be straightforward and uncomplicated. The interpreter is present to convert a message uttered in one language into another. Professional interpreters, however, understand the

profound complexities of what appears to be this simple task. In fact, even in the most simple of encounters, the interpreter can be faced by a series of dilemmas they need to recognize and address.

In face-to-face, interpreter-assisted, medical encounters, the very presence of the interpreter changes the power dynamic of the original dyadic relationship between patient and provider. In a very significant way, the interpreter holds tremendous power because they are often the only ones present in the encounter who understand both languages involved. In addition, the interpreter enters the interaction as an independent entity with their own beliefs and feelings. Both the patient and the provider have to be able to trust that the interpreter will not abuse this power. They need to trust that the interpreter will transmit faithfully what it is they each have to convey to each other and not what the interpreter thinks. They also need to trust that the interpreter will uphold the private and confidential nature of the clinician-patient relationship. "It is the function of a code of ethics to guide the interpreter on how to wield that power" (Edwards, 1988, p. 22). A code of ethics provides guidelines and standards to follow, creating consistency and lessening arbitrariness in the choices interpreters make in solving the dilemmas they face (Gonzalez, et al., 1991).

POTENTIAL USES

These standards of practice can be used for several purposes.

1. *Guideposts in the development of educational and training programs:* Too often educational and training programs are developed without clearly articulated connections to performance expectations in the field. These standards of practice were developed by practitioners with years of experience in the field who are also responsible for on-the-job training and supervision. As such, they reflect a comprehensive view of the basic skills and knowledge required on the job. Used as guideposts, these standards can serve as the foundation of course and/or training objectives.

2. *Evaluation Tool:* Standards of practice can serve as pre-selected criteria against which the performance of students, trainees, or practitioners in the field can be evaluated. As a formative evaluation tool in the academic or training setting, both the student and the instructor can use the indicators to provide on-going

feedback on the skills the student needs to work, the tasks in which they have achieved mastery and the tasks they still need to learn or improve. As an outcome measure, the standards can be used to determine whether or not a student has achieved mastery of the required skills. At the workplace, these standards can be used to assess the level of competency at the point of entry, that is, as an assessment tool, and as a supervisory tool to provide on-going feedback. The individual interpreter can also use these standards to continue to monitor and assess their own performance.

3. *Preparation of health care providers to work with interpreters:* These standards provide health care providers with a comprehensive overview of what to expect from interpreters.

4. *Foundation for a certification examination:* Since these standards represent a comprehensive articulation of the basic skills and knowledge a competent interpreter must master, they can be used as the foundation for the development of a performance-based portion of a certification examination. For example, the potential candidate for certification would be placed in a role play that was designed to include both a routine interpreting interaction as well as an unanticipated problem. The role play would require that the interpreter be able to demonstrate in an integrated way the application of a variety of tasks in order to address the situation in an appropriate, professional manner.

LOOKING TO THE FUTURE

Medical interpreting as a profession is in its infancy. The members of the MMIA's Subcommittee on Standards of Practice recognize that this document represents a first step in what needs to be an ongoing, developmental process. It is expected that by simultaneously setting clear, high performance standards and creating rigorous training and academic programs, a marked increase in the quality of interpreting in the health care arena will follow. This increase in quality will in turn lead to full recognition of competent, professional interpreters, according them the status and compensation commensurate with the critical nature of their work, and creating a demand for higher-level training and academic programs.

MEDICAL INTERPRETER STANDARDS OF PRACTICE
DUTY A: INTERPRETATION

A-1 Introduce self and explain role.

Indicators of Mastery		Indicators of Lack of Mastery
A) When possible, holds a pre-conference to find out the providers goals for the encounter and other relevant background information.	5 4 3 2 1 (See rating guidelines)	A) Does not attempt to hold a pre-conference even when possible.

B) Introduces themselves * and their role briefly and succinctly to provider and patient as follows:
• gives their name
• indicates language of interpretation
• checks on whether either provider or patient has worked with interpreter before
• explains role, emphasizing
  • goal of ensuring effective provider-patient communication
  • confidentiality
  • accuracy and completeness (i.e., everything said by either will be transmitted)
  • explains use of the first person form, especially if provider and/or patient are unfamiliar with this
• asks if there are any questions about interpreter's role
• answers any questions
	5 4 3 2 1	B) Introduction is missing one or more components.

* The third person plural form is used as a gender-neutral substitute for the third person singular pronoun.

A-1 Introduce self and explain role (continued).

C) In the event that a pre-conference cannot be held and/or a full introduction made, at a minimum, the interpreter asks provider to briefly state their goal for the encounter and informs patient and provider that their role obliges them to transmit everything that is said in the encounter to each other; therefore, if either party wishes something to be kept in confidence from the other, it should not be said in the presence of the interpreter.	5 4 3 2 1	C) Does not fulfill this minimum requirement.
D) Establishes and asserts their role from the beginning.	5 4 3 2 1	D) Shows uneasiness in establishing and asserting their role.
E) Introduction is clear and well paced.	5 4 3 2 1	E) Introduction is confusing; pacing is ineffective.
F) Is able to adjust the introduction in response to the demands of the situation.	5 4 3 2 1	F) Is not flexible to the demands of the situation.

A-2 Manage the spatial configuration of patient-provider-interpreter in order to maximize ease and directness of communication.

Indicators of Mastery		Indicators of Lack of Mastery
A) Interpreter is able to hear and see both patient and provider.	5 4 3 2 1	A) Interpreter strains to hear and/or maintain visual contact with either or both.
B) Interpreter can be seen and heard by both.	5 4 3 2 1	B) Interpreter cannot be seen or heard by both.
C) Spatial configuration supports direct communication between provider and patient.	5 4 3 2 1	C) Spatial configuration places the interpreter at the center of communication or otherwise disrupts direct communication.
D) Interpreter respects the spatial and visual privacy of the patient when necessary (e.g., stands behind a screen during physical exam), while maintaining, when possible, and/or necessary, enough visual contact to "read the patient's face."	5 4 3 2 1	D) The physical location of the interpreter makes the patient uncomfortable in situations where the spatial and visual privacy of the patient is necessary.

A-3 Maintains the linguistic register and style of the speaker.

Indicators of Mastery		Indicators of Lack of Mastery
A) When possible, speaks to the patient prior to the triadic encounter to asses the patient's linguistic register and style (e.g. dialect, formality of speech, etc.)	5 4 3 2 1	A) Does not asses the patient's linguistic register or style.
B) Preserves the register and style of language used in the source language when transmitting in the target language.	5 4 3 2 1	B) Changes the register or style of language used in the source language when transmitting in the target language.

A-4 Address the "comfort needs" of patient in relationship to the interpreter with regards to factors such as age, gender, and other potential areas of discomfort.

Indicators of Mastery		Indicators of Lack of Mastery
A) When the issue arises, assesses potential areas of discomfort for the patient (e.g., gender or age of the interpreter) and discusses them with the patient.	5 4 3 2 1	A) Does not assess potential areas of discomfort.
B) Is cognizant of body language and/or specific verbalization suggesting discomfort and • checks to identify the source of distress • reassures the patient by informing them about their credentials, professionalism, and the ethics of confidentiality • explains the reality of the situation (e.g., they may be the only interpreter available) and tries to put the patient at ease • offers options to address the discomfort, when available	5 4 3 2 1	B) Ignores signs of discomfort and does nothing about them.

A-5 **Select appropriate mode of interpretation (consecutive, simultaneous; 1st or 3rd person).**

Indicators of Mastery		Indicators of Lack of Mastery
A) Uses the mode that best enhances comprehension and least interrupts the speaker's train of thought, given the demands of the situation.	5 4 3 2 1	A) Does not use the mode that best enhances comprehension and least interrupts the speaker's train of thought, given the demands of the situation.
B) Uses the mode that best preserves accuracy.	5 4 3 2 1	B) Does not use the mode that best preserves accuracy.
C) If the interpreter is competent in the simultaneous mode, uses it when it is important that the speaker not be interrupted (e.g., psychiatric interview, periods of high emotion.)	5 4 3 2 1	C) Does not demonstrate the use of alternative strategies to provide accurate and complete interpretation in such cases.
D) Can switch from one mode to the other as needed.	5 4 3 2 1	D) Cannot switch from one mode to the other as needed.
E) Can explain the reason for the switch, briefly and unobtrusively, if needed.	5 4 3 2 1	E) Cannot explain the switch briefly and unobtrusively.
F) Uses modes of interpreting in which they are competent and comfortable.	5 4 3 2 1	F) Uses a mode in which they are not competent.

A-6 Accurately transmit information between patient and provider.

Indicators of Mastery		Indicators of Lack of Mastery
A) Message transmission is accurate. Re-expresses the message conveyed in one language into its equivalent in the other language, so that the interpreted message has the potential for eliciting the same response as the original.	5 4 3 2 1	A) Message transmission is inaccurate: • the transmitted message is not equivalent to the original; the message is different • the elicited response does not match the intended message
B) Message transmission is complete (i.e., includes denotative, connotative, and metanotative meaning, taking into account the context, content, function, affect, register of the original message.)	5 4 3 2 1	B) Message transmission is incomplete • propositions are missing • function and affect are not conveyed • improper paraphrasing
C) Asks for clarification or repetition of information and/or concepts they do not understand or did not completely hear.	5 4 3 2 1	C) Omits, makes up, or inaccurately interprets information and/or concepts they did not understand or completely hear.
D) Effectively uses mnemonic devices (e.g., note taking, visualization, etc.) to aid retention of information and accuracy of interpretation.	5 4 3 2 1	D) Does not effectively use mnemonic devises to aid retention and accuracy.
E) Can explain the ramifications of inaccurate interpreting.	5 4 3 2 1	E) Cannot explain the ramifications of inaccurate interpretation.

A-7 Encourage direct communication between patient and provider.

Indicators of Mastery		Indicators of Lack of Mastery
A) Suggests that patient and provider address each other directly.	5 4 3 2 1	A) Does not suggest or explain that provider and patient should address each other directly.
B) Uses the first person ("I") form as the standard, but can switch to the third person when the first person form causes confusion.	5 4 3 2 1	B) Does not use the first person form as the standard.
C) Patient and provider address each other directly.	5 4 3 2 1	C) Provider and/or patient direct their communication to interpreter.
D) When necessary, cues provider and patient to return to direct communication.	5 4 3 2 1	D) Does not cue patient and/or provider to address each other directly when necessary.

A-8 Ensure that the listener understands the message.

Indicators of Mastery		Indicators of Lack of Mastery
A) Picks up on verbal and nonverbal cues that may indicate the listener is confused or does not understand.	5 4 3 2 1	A) Does not pay attention to verbal and nonverbal cues indicating possible confusion or lack of understanding.
B) Checks whether clarification is needed by the listener.	5 4 3 2 1	B) Does not check to see whether clarification is needed.
C) If needed, asks the speaker to give further explanation or to say the same thing using different words.	5 4 3 2 1	C) Does not request explanation or further clarification from speaker.

A-9 Ensure that the interpreter understands the message to be transmitted.

Indicators of Mastery		Indicators of Lack of Mastery
A) Asks for repetition if message is not understood or not heard, clarifying that it is due to the interpreter's need.	5 4 3 2 1	A) Ignores and omits messages they did not understand or hear completely.
B) Asks for explanation or asks speaker to say the same thing using other words.	5 4 3 2 1	B) Guesses at what the speaker said or meant and transmits this.
C) Verifies the meaning the interpreter understood especially in situations of possible ambiguity.	5 4 3 2 1	C) Does not verify meaning.

A-10 Manage the flow of communication in order to preserve accuracy and completeness, and to build rapport between provider and patient.

Indicators of Mastery		Indicators of Lack of Mastery
A) Manages conversational turn-taking so that only one person talks at a time. Interpreter can interpret only one voice at a time.	5 4 3 2 1	A) Does nothing to manage conversational turn-taking when people talk at the same time, so that interpreter ceases to be able interpret.
B) Asks the speaker to pause, when necessary, in order to maintain accuracy and completeness.	5 4 3 2 1	B) Interpreter does not take the initiative to interpret in a timely manner in order to maintain accuracy and completeness.
C) When necessary, asks the speaker to pause in order to allow the other to speak and express themselves.	5 4 3 2 1	C) Patient or provider does not get a chance to talk.
D) Asks the speaker to pause in a manner that is least disruptive and most culturally appropriate.	5 4 3 2 1	D) Interrupts the speaker in a manner that is disruptive and culturally inappropriate.
E) Manages the timing of interpretations so that neither party feels or is left out of the communication loop.	5 4 3 2 1	E) There are exchanges where one of the parties (either the provider or patient) does not know what is being said for an extended period of time.
F) Clearly indicates when the interpreter is speaking as themselves.	5 4 3 2 1	F) Gives no indication they are speaking as themselves.

A-11 Manage the dynamics of the triad.

Indicators of Mastery		Indicators of Lack of Mastery
A) Manages the flow of communication to enhance the patient-provider relationship.	5 4 3 2 1	A) Does not manage the flow of communication.
B) Appropriately addresses cultural issues.	5 4 3 2 1	B) Overexplains possible cultural issues or ignores them.
C) Can assert interpreter role when necessary.	5 4 3 2 1	C) Cannot assert interpreter role when necessary.
D) Remains low-key, when communication is going well and there is no reason to interfere.	5 4 3 2 1	D) Is too obtrusive.
E) Keeps "personal issues" (feelings, biases, opinions) out of the triadic interview.	5 4 3 2 1	E) Interjects own personal issues into the triadic interview.
F) Encourages direct communication between patient and provider.	5 4 3 2 1	F) Keeps focus of communication on themselves.
G) Respects and enhances each person's primary sphere of "power"/expertise (i.e., the patient is the expert on their own body and has decision-making power for themselves; the provider has medical expertise and their power lies in the knowledge they have which the patient does not have; the interpreter has expertise understanding the two language systems and in converting messages from one language to the other.)	5 4 3 2 1	G) Interpreter takes over the role of the patient and/or provider. (e.g., tells the patient what to do; makes up or adds symptoms, instructions; gives medical advice, etc.)

A-12 Manage personal internal conflict.

Indicators of Mastery		Indicators of Lack of Mastery
A) Can identify and discuss their own personal values/beliefs that may create internal conflicts for them in certain medical situations.	5 4 3 2 1	A) Is not aware of and cannot articulate areas of potential internal conflict.
B) Can clearly separate their own values/beliefs from those of the other.	5 4 3 2 1	B) Projects their own personal values/beliefs into the situation and as a result loses the meaning the speaker intended.
C) Is able to withdraw from situations where strongly held personal values/ beliefs may interfere with impartiality.	5 4 3 2 1	C) Continues interpreting even when they may not be the appropriate interpreter and attempts to influence provider and/or patient to bring them in line with their own values and beliefs rather than allowing them to hold and express their own values.
D) Can acknowledge potential areas of conflict within self and make this explicit prior to the start of the interview, especially where no other alternatives are available (e.g., be able to say, "I need you to know this topic may be difficult for me but I will try").	5 4 3 2 1	D) Does not make explicit potential areas of internal conflict which may interfere with their ability to interpret accurately and completely.

A-13 Manage conflict between provider and patient.

Indicators of Mastery		Indicators of Lack of Mastery
A) Remains calm in stressful situations or when there is conflict.	5 4 3 2 1	A) Appears agitated, distressed when there is conflict.
B) Acknowledges when there is conflict/ tension between provider and patient.	5 4 3 2 1	B) Ignores or pretends there is no conflict/tension.
C) Assists the provider and patient make conflicts/tensions explicit so that they can work it out between themselves.	5 4 3 2 1	C) Tries to solve or handle the conflict themselves; does not make the issue(s) explicit.
D) Lets each party speak for themselves and does not take sides in the conflict.	5 4 3 2 1	D) Takes sides and/or speaks for the parties.

A-14 Do a self-check on accuracy of interpretation and correct own mistakes.

Indicators of Mastery		Indicators of Lack of Mastery
A) Identifies own mistakes.	5 4 3 2 1	A. Does not recognize or acknowledge own mistakes.
B) Stops and corrects own mistakes.	5 4 3 2 1	B) Does not correct their own mistakes.
C) When mistakes are pointed out, they are able to accept this information and take steps to learn from the feedback.	5 4 3 2 1	C) Denies or makes excuses for mistakes when they are pointed out; makes no attempt to benefit from feedback.

A-15 Assist the provider with interview closure activities.

Indicators of Mastery		Indicators of Lack of Mastery
A) Encourages the provider to give appropriate instructions, make sure the patient is clear about next steps and has asked any questions they may still have.	5 4 3 2 1	A) Does not encourage the provider to give appropriate instructions, make sure the patient is clear about next steps, or ask any questions they may still have.
B) Checks with patient as to the need for an interpreter at any of the follow-up steps.	5 4 3 2 1	B) Does not check with patient as to the need for an interpreter at any of the follow-up steps.
C) Observes "closure etiquette" or makes closing remarks appropriate to each party.	5 4 3 2 1	C) Does not observe "closure etiquette" or make closing remarks appropriate to each party.

A-17 Complete appropriate documentation of the interpreter's work.

Indicators of Mastery		Indicators of Lack of Mastery
A) Finds out what the protocols are for each institution/health care setting in which they work.	5 4 3 2 1	A) Does not find out what protocols the institution requires.
B) Knows and uses the protocols for each setting.	5 4 3 2 1	B) Does not know and /or use the protocols for each setting.
C) Follows the documentation policies/procedures/guidelines of each institution's interpreter office, which may include • keeping phone log • documenting all follow-up activities, such as follow-up appointments • completing weekly invoice of hours worked • submitting documentation to the appropriate person or filing documentation in the appropriate place and in a timely manner • keeping interpreter office informed of their location (i.e., where assigned)	5 4 3 2 1	C) Does not follow the documentation policies/ procedures/guidelines of the institution, resulting in the following possible situations: • errors in follow-up activities • priorities are mishandled • interpreter does not get paid • interpreter office cannot locate interpreter • at the end of the year, statistics are incomplete or inaccurate

A-18 Followup (outside the triadic encounter) as necessary.

Indicators of Mastery		Indicators of Lack of Mastery
A) When requested, notifies patients of follow-up, canceled, or rescheduled appointments.	5 4 3 2 1	A) Does not notify patients of follow-up, canceled, or rescheduled appointments, when requested.
B) When requested, reschedules appointments for patients.	5 4 3 2 1	B) When requested, does not reschedule appointments for patients.
C) When involved in follow-up telephone calls, conveys information back and forth, following the same principles of accuracy and completeness.	5 4 3 2 1	C) Does not follow the same principles of accuracy and completeness when involved in telephone communications.

DUTY B: CULTURAL INTERFACE

B-1 Use culturally appropriate behavior.

Indicators of Mastery		Indicators of lack of Mastery
A) Observes the rules of cultural etiquette and/or institutional norms (e.g., regarding behavior and language suited to age, gender, hierarchy, status, level of acculturation) appropriate to each party.	5 4 3 2 1	A) Does not observe the rules of cultural etiquette and/or institutional norms appropriate to each party.
B) Adjusts behavior in order to observe the appropriate rules of cultural etiquette.	5 4 3 2 1	B) Does not adjust behavior in order to observe the appropriate rules of cultural etiquette.

B-2 Recognize and address instances that require intercultural inquiry to ensure accurate and complete understanding.

Indicators of Mastery		Indicators of lack of Mastery
A) Pays attention to verbal and nonverbal cues that may indicate implicit cultural content or culturally based miscommunication (e.g., responses do not fit the transmitted message; discomfort or distress is shown when certain topics are brought up).	5 4 3 2 1	A) Ignores verbal/non-verbal cues indicating implicit cultural content or culturally based miscommunication.
B) Assesses the urgency/centrality of the issue, at that point in time and in that particular exchange, to the goals and outcomes of the encounter: • assesses the best time and method by which to raise the issue • interjects and makes explicit what the problem might be to both parties • prompts the provider and patient to search for clarity	5 4 3 2 1	B) Does not assess the urgency/centrality of the issue; interpreter becomes barrier to communication: • interjects disruptively (e.g., too frequently or unnecessarily) • does not make explicit the problem to both parties • takes over by telling provider and/or patient what the problem is
C) Shares cultural information with both parties that may be relevant and may help clarify the problem (e.g., interpreter says, "It's possible this is what is happening because often people from_____ believe that . . .").	5 4 3 2 1	C) Makes cultural assumptions and acts on them (e.g., tells the person what cultural stereotypes to live up to).
D) In cases where "untranslatable" * words are used, the interpreter assists the speaker to develop an explanation that can be understood by the listener.	5 4 3 2 1	D) Does not assist the speaker develop explanations for "untranslatable" words; explains the words themselves or omits the concepts.

* Untranslatable words—words that represent concepts for which a referent does not yet exist in the society using the target language.

DUTY C: ETHICAL BEHAVIOR

C-1 Maintain confidentiality.

Indicators of Mastery		Indicators of lack of Mastery
A) Can explain the boundaries and the meaning of confidentiality, its implications and consequences.	5 4 3 2 1	A) Cannot explain the boundaries and the meaning of confidentiality, its implications and consequences.
B) Knows and maintains the clinical parameters of information sharing, in keeping with the policies and procedures of the institution and/or team e.g. • supervision • patient conferences/continuity of care meetings • professional meetings, workshops, conferences. (Ensures that any information shared at professional meetings does not contain identifying characteristics (e.g. hospital, names, date of encounter, etc.) that can be attached to a specific individual. In other words, the interpreter is responsible for maintaining the anonymity of the parties in the situation	5 4 3 2 1	B) Intentionally or unintentionally reveals confidential information outside the medical parameters.
C) Knows how to respond to questions dealing with confidential matters that may be brought up in the community or health care setting.	5 4 3 2 1	C) Does not know how to deflect inappropriate requests for information and violates confidentiality.
D) In cases where the interpreter becomes privy to information regarding suicidal/homicidal intent, child abuse, or domestic violence, acts on their obligation to transmit such information, in keeping with institutional policies, interpreter standards of practice and code of ethics, and the law.	5 4 3 2 1	D) Fails to act on their obligation to transmit information to relevant parties.

C-2 Interpret accurately and completely.

Indicators of Mastery		Indicators of lack of Mastery
A) Can explain the concepts of accuracy and completeness, their implications and consequences.	5 4 3 2 1	A) Cannot explain the concepts of accuracy and completeness, their implications and consequences.
B) Is committed to accurately and completely transmitting the content and spirit of the original message into the other language, without omitting, modifying, condensing, or adding.	5 4 3 2 1	B) Is not committed to accurately and completely transmitting the content and spirit of the original message.
C) Is committed to monitoring their own interpreting performance.	5 4 3 2 1	C) Does not monitor their own interpreting performance.
D) Has the moral fortitude to admit and correct their own mistakes.	5 4 3 2 1	D) Does not have the moral fortitude to admit and correct their own mistakes. Permits mistakes to stand uncorrected.

C-3 Maintain impartiality.

Indicators of Mastery		Indicators of lack of Mastery
A) Is aware of and able to identify personal biases and beliefs that may interfere with their ability to be impartial. Has the moral fortitude to withdraw if they cannot be impartial.	5 4 3 2 1	A) Is unaware of and unable to identify personal biases and beliefs that may interfere with their ability to be impartial. Does not have the moral fortitude to withdraw if they cannot be impartial.
B) Withdraws or refrains from accepting any assignment where close personal or professional ties or strong personal beliefs may affect impartiality (including conflict of interests) unless an emergency renders the service necessary.	5 4 3 2 1	B) Accepts assignments where close personal or professional ties or strong personal beliefs may affect impartiality, even when other alternatives are available.
C) Focuses on the communication between provider and patient and refrains from interjecting personal issues, beliefs, opinions, biases into the interview, motivated by a commitment to impartiality.	5 4 3 2 1	C) Interjects personal issues, beliefs, opinions, biases into the interview.
D) Refrains from counseling or advising.	5 4 3 2 1	D) Counsels and advises.

C-4 Respect patient's privacy.

Indicators of Mastery		Indicators of lack of Mastery
A) Respects patient's physical privacy. Maintains spatial/visual privacy of patient, as necessary.	5 4 3 2 1	A) Does not respect patient's physical privacy. Does not maintain spatial/visual privacy of patient.
B) Respects patient's "personal/ emotional" privacy • refrains from asking personal, probing questions, outside the scope of interpreting tasks • does not use their role as interpreter to influence their social relationship with the patient outside the interpreting encounter • refrains from getting personally involved in the lives of the patients *	5 4 3 2 1	B) Does not respect patient's "personal/emotional" privacy: • asks personal, probing questions on their own initiative • uses their role as interpreter to influence their social relationship with the patient outside the interpreter's encounter • gets personally involved

* In small, close-knit communities, it is often not possible for an interpreter to remain personally and socially uninvolved with patients. However, interpreters should always strive to maintain the ethical and professional standards of confidentiality and impartiality while in their role.

C-5 Maintain professional distance.

Indicators of Mastery		Indicators of lack of Mastery
A) Can explain the meaning of professional distance, its implications and consequences.	5 4 3 2 1	A) Cannot explain the meaning of professional distance, its implications and consequences.
B) Is able to balance empathy with the boundaries of the interpreter role.	5 4 3 2 1	B) Is not able to balance empathy with the boundaries of the interpreter role.
C) Shows care and concern for patient needs by facilitating the use of appropriate resources.	5 4 3 2 1	C) Ignores patient needs or tries to solve everything for the patient.
D) Refrains from getting personally involved, thereby fully supporting the provider-patient relationship.	5 4 3 2 1	D) Gets personally involved such that the provider-patient therapeutic relationship is sabotaged or compromised, thereby misleading the patient as to who the provider is and effectively disempowering the provider.
E) Does not create expectations in either party that the interpreter cannot fulfill in their role.	5 4 3 2 1	E) Creates expectations in either party that the interpreter cannot fulfill in their role.
F) Promotes patient self-sufficiency, taking into account the social context of the patient.	5 4 3 2 1	F) Encourages and/or creates patient dependency on the interpreter.
G) Monitors their own personal agenda and needs; is aware of transference and counter transference issues.	5 4 3 2 1	G) Is unaware of transference and counter transference issues.

C-6 Maintain professional integrity.

Indicators of Mastery		Indicators of lack of Mastery
A) Refrains from contact with patient outside the scope of employment, avoiding personal benefit.	5 4 3 2 1	A) Initiates contact with patient outside scope of employment for personal benefit.
B) Refrains from fulfilling any functions or services that are not part of the interpreter role.	5 4 3 2 1	B) Takes on functions or provides services that are not part of the interpreter role.
C) Knows the limits of their competencies and refrains from interpreting beyond their training, level of experience, and skills, unless their limitations are fully understood by the patient and provider and no other source of interpreting is available.	5 4 3 2 1	C) Is not aware of the limits of their competencies and places themselves in situations that are beyond their level of training, skill, and/or experience; on occasions where no other source of interpreting is available, does not inform patient or provider of their limitations.
D) Refrains from interpreting in situations where there may be a conflict of interest.	5 4 3 2 1	D) Persists in functioning as an interpreter in situations where there may be a conflict of interest.
E) Engages in ongoing professional development.	5 4 3 2 1	E) Does not engage in ongoing professional development.

C-7 Deal with discrimination.

Indicators of Mastery		Indicators of lack of Mastery
A) On occasions where the interpreter feels strongly that either party's behavior is affecting access or quality of service, or compromising any party's dignity, the interpreter uses effective strategies to address the situation.	5 4 3 2 1	A) Does nothing or addresses the situation in an ineffective, disruptive manner.
B) If the problem persists, knows and uses institutional policies and procedures relevant to discrimination.	5 4 3 2 1	B) Does not know or use institutional policies and procedures relevant to discrimination.

Rating Scale

5 Fulfills the expectation completely and consistently, with ease and fluidity
4 Fulfills the expectation in a mechanical way
3 Performs the expectation but with hesitation or lack of confidence
2 Performs inconsistently; lapses into behaviors demonstrating lack of mastery
1 Is unable to perform the task; behaviors consistent with lack of mastery

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